COLUMBUS
DENTAL ARTS

New Patient Information

Patient Name: _____

Home Phone Number: _____

Cell phone number: _____

E-mail: _____

In case of emergency, please contact: _____
Relationship to Patient: _____
Emergency Contact number: _____

Please mark if you are currently taking, or have ever taken, one of the following medications:

Oral	Intravenous
_____Actonel	_____ Aredia
_____ Boniva	_____ Zometa
_____ Fosamax	_____Bonefos
_____Fosamax Plus D	_____ Reclast Therapy
_____ Skelid	_____Xgeva
_____ Didronel	_____ Pamidronate
_____ Risedronate	_____ Zolendronic Acid
_____ Ibandronate	_____Clodronate
_____ Alendronate	_____ Denosumab
_____Tiludronate	_____ Prolia
_____ Etidronate	

If yes to any of the above, please give dates and duration:

_____

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Dear Patient,

One of the most important services we provide is the periodic exam and prophylaxis. During your re-care appointment we will do some or all of the following:

- Medical History Update
- Oral Cancer Screening
- Radiographic Screening (x-rays)
- Cavity Detection
- Desensitizing Therapy
- Fluoride Treatment
- Antibacterial Irrigation
- Dental Cleaning
- Oral Hygiene Instructions

In order to perform these services properly, we allow 40 to 60 minutes in our schedule exclusively for you. We require a 48 hour notice to change or cancel your appointment. In an effort to control escalating costs and continue to provide outstanding and thorough service, we have the following policies:

- Same Day cancellation/less than 24 hour notice - **$50** charge to account
- Missed appointment/No-show - **$75** charge to account

We look forward to developing a positive relationship.

Sincerely,
Columbus Dental Arts

Patient Signature_____ Date_____

Confidential Health History Report

Name_____ Home Phone _____

Address_____ City_____ State_____ Zip _____

Date of Birth _____ Age _____ Sex: Male___ Female___

Dental Information

Do your gums bleed when you brush? Yes___ No___ Sometimes___

Are your teeth sensitive to cold, hot, sweets or pressure? Yes___ No___ Sometimes___

Do you have headaches, earaches or neck pain? Yes___ No___ Sometimes___

Have you ever had orthodontic treatment (braces)? Yes___ No___

Have you ever had periodontal (gum) treatment? Yes___ No___

Do you wear removable dental appliances? Yes___ No___

Have you ever had a serious/difficult problem associated with previous dental treatment? Yes___ No___

If so, explain_____

Previous Dentist_____

Date of last dental exam _____ Date of last dental x-rays_____ Date of last dental cleaning_____

Do you have any current dental problems?_____

Medical Information

Physician(s) _____ Phone Number_____

Preferred Pharmacy _____ Phone Number _____

Describe your overall health condition? _____Has it changed within the year? Yes___No___

Are you under the care of a physician? Yes___ No___ If so, for what condition? _____

Please List ALL medications you are currently taking (prescription and non-prescription)

_____

_____

_____

_____

Have you had any illness, operation, or been hospitalized in the past 5 years? Yes___ No___

If so, what was the illness/problem? _____

Have you taken any diet drugs, such as Pondimin (fenfluramine) Redux (dexfenfluramine) or Phen-fen (fenfluramine-phentermine combination)? Yes___ No___

Do you drink alcoholic beverages? Yes___ No___ Sometimes___ How much in the last 24hrs? _____

Do you use tobacco (smoking/snuff/chew)? Yes___No___Sometimes___ How much in the last 24hrs? _____

Do you use drugs/other substances for recreational purposes? Yes___No___Sometimes____ How much in a day? _____

Do you have:

Active Tuberculosis? Yes___ No___

A persistent cough greater than 3-week duration? Yes___ No___

Cough that produces blood? Yes___ No___

Have you had any orthopedic joint replacements? Yes___No___ Which joint(s)? _____ When? _____

Have you had any complications with joint replacements? Yes___ No___ If so, explain_____

Has a physician or dentist recommended that you take antibiotics prior to dental treatment? Yes__ No___

If so, what antibiotic and dose? _____

WOMEN: Are you pregnant? Yes___ No___ Unsure____

Nursing? Yes___ No___

Taking birth control pills? Yes___ No___

CONTINUED ON OTHER SIDE

Allergies

Please mark if you are allergic or have had a reaction to:

_____Local Anesthetics
_____ Aspirin
_____Penicillin or other antibiotics
_____Latex
_____ Codeine or other narcotics
_____ Sulfa drugs
_____ Barbiturates, sedatives or sleeping pills
_____Iodine
_____Hay fever/seasonal
_____ Animals
_____ Food (specify) _____
_____ Other _____

If yes to any of the above, please specify type of reaction _____

PLEASE MARK IF YOU HAVE OR HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

_____ Abnormal Bleeding
_____AIDS or HIV infection
_____ Anemia
_____ Arthritis
_____ Rheumatoid Arthritis
_____ Asthma
_____Blood transfusion
Date_____
_____ Cancer/chemotherapy/radiation
Specify type of cancer_____
_____ Cardiovascular disease
Specify:
_____Angina
_____Arteriosclerosis
_____ Artificial heart valve
_____ Coronary insufficiency
_____ Coronary occlusion
_____ Damaged heart valves
_____ Heart attack
_____ Heart murmur
_____ High blood pressure
_____ Inborn heart defects
_____ Mitral valve prolapse/regurgitation
_____ Pacemaker
_____ Rheumatic heart disease
_____Chest pain upon exertion
_____ Chronic pain
_____ Persistent diarrhea
_____ Disease, drug or radiation-induced immunosuppression
_____ Diabetes (Specify)
_____Type I (insulin dependent)
_____ Type II
_____ Dry mouth
_____ Eating disorder
Specify_____
_____ Epilepsy
_____ Fainting Spells or seizures
_____ G.E. Reflux
_____ Glaucoma
_____Hemophilia
_____ Hepatitis, jaundice or liver disease
_____Recurrent infections
Specify type of infection_____
_____Kidney problems
_____ Low blood pressure
_____ Lyme's Disease
_____ Mental Health Disorders
Specify type of disorders _____
_____ Malnutrition
_____ Migraines
_____ Night sweats
_____ Neurological disorders
Specify type of disorders _____
_____ Osteoporosis
_____ Persistent swollen glands in neck
_____ Respiratory problems (specify)
_____ Emphysema
_____ Bronchitis, etc.
_____ Scarlet Fever
_____ Severe Headaches
_____ Severe or rapid weight loss
_____ Sexually transmitted disease
_____ Sinus trouble
_____ Sores or ulcers in the mouth
_____Sleep disorder
_____ Stroke
_____ Systemic lupus erythematosus
_____ Thyroid problems
_____ Tuberculosis
_____ Ulcers
_____ Excess urination

Do you have any disease, condition, or problem not listed above you think we should know about? Yes___ No___
Explain: _____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Columbus Dental Arts

Acknowledgement of Receipt of Notice of Privacy Practices

you may refuse to sign this acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices, and I am aware that I may access this notice on Columbus Dental Art's website at any time.

_____

Print Name

_____

Signature

_____

Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining the acknowledgement
- _____ Other (please specify)

  _____

  _____

  _____

REGISTRATION **Date**_____

(PLEASE PRINT)

PATIENT INFORMATION

Name_____ Soc. Sec #_____
Last *First* *Initial*

Address_____

City_____ State_____ Zip_____

Sex: Male___ Female___ Age____ Birthdate_____ Status: Single____ Married____ Widowed____ Separated____ Divorced_____

Patient Employed by_____ Occupation_____

Business Address_____Phone_____

Whom may we thank for referring you? _____

Emergency Contact _____Phone _____

PRIMARY INSURANCE

Subscriber_____
Last Name *First Name* *Middle*

Relationship to Patient_____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient)_____ Phone _____

City_____ State _____ Zip_____

Subscriber Employed By_____ Occupation _____

Insurance Company_____ Subscriber ID #_____

Group #_____ Contract # _____

Other Dependents under this plan _____

ADDITIONAL INSURANCE (if any)

Subscriber_____
Last Name *First Name* *Middle*

Relationship to Patient_____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Phone _____

City_____ State _____ Zip_____

Subscriber Employed By_____ Occupation _____

Insurance Company_____ Subscriber ID #_____

Group #_____ Contract # _____

Other Dependents under this plan _____

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with _____ and assign directly Columbus Dental Arts 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature *Relationship to Patient* *Date*