New Patient Information

NAME _____

HOME NUMBER _____

WORK NUMBER _____

CELL NUMBER _____

In case of emergency, please contact: _____

Relationship to patient: _____

Emergency contact number: _____

EMAIL _____

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

ORAL	INTRAVENOUSLY
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, please give dates and duration: _____

CONFIDENTIAL HEALTH HISTORY

Name _____ Home Phone (___) _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Height _____ Weight _____ Sex ☐ M ☐ F

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 pains?	☐ yes	☐ no	☐ sometimes
Have you ever had orthodontic (braces) treatment?	☐ yes	☐ no	
Have you ever had periodontal (gum) treatment?	☐ yes	☐ no	
Do you wear removable dental appliances?	☐ yes	☐ no	

Have you had a serious/difficult problem associated with any previous dental treatment? ☐ yes ☐ no

If so, explain _____

Who was your previous dentist? _____

Date of your last dental exam _____ Date of last dental x-rays _____ Date of last dental cleaning _____

Describe your current dental problem _____

_____

What improvements would you like to see in your smile? _____

MEDICAL INFORMATION

Physician (s) names _____ Phone number _____

Preferred pharmacy _____ Phone number _____

Describe your overall health condition? _____ Has it changed within the past 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 (include prescription and non-prescription and daily dosages) _____

_____

_____

_____

_____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? ☐ yes ☐ no

If so, what was the illness or problem? _____

Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? ☐ yes ☐ no

Do you drink alcoholic beverages? ☐ yes ☐ no ☐ sometimes Approximately how much in the last 24 hours? _____

Do you use drugs/other substances for recreational purposes? ☐ yes ☐ no What have you used in the last 24 hours? _____

Do you use tobacco (smoking, snuff, chew)? ☐ yes ☐ no ☐sometimes Approximately how much in an average day? _____

Do you wear contact lenses? ☐ yes ☐ no

Do you have any of the following diseases or problems?	Active tuberculosis?	☐ yes	☐ no
	Persistent cough greater than a 3-week duration?	☐ yes	☐ no
	Cough that produces blood?	☐ yes	☐ no

Have you had an orthopedic total joint replacement? ☐ yes ☐ no Which joint? _____ When? _____

Have you had an complications with your prosthetic joint? ☐ yes ☐ no If so, explain _____

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ☐ yes ☐ no

If so, what antibiotic and dose? _____

WOMEN: Are you pregnant? ☐ yes ☐ no ☐ don't know

Nursing? ☐ yes ☐ no

Taking birth control pills? ☐ yes ☐ no

(CONTINUED ON REVERSE SIDE)

ALLERGIES

Please (X) if you are allergic to or have had a reaction to:

_____ Local anesthetics
_____ Aspirin
_____ Penicillin or other antibiotics
_____ Latex
_____ Sulfa drugs
_____ Codeine or other narcotics
_____ Barbiturates, sedatives or sleeping pills
_____ Iodine
_____ Hay fever/seasonal
_____ Animals
_____ Food (Specify)_____
_____ Other _____

To the yes responses, specify type of reaction_____

PLEASE (X) 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
If yes, date_____
_____ Cancer/chemotherapy/radiation
If yes, specify_____
_____ Cardiovascular disease
If yes, 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
_____ Pacemaker
_____ Rheumatic heart disease
_____ Chest pain upon exertion
_____ Chronic pain
_____ Persistent diarrhea
_____ Disease, drug, or radiation-induced immunosurpression
_____ Diabetes. If yes, specify
_____ Type I (insulin dependent)
_____ Type II
_____ Dry mouth
_____ Eating disorder
If yes, specify _____
_____ Epilepsy
_____ Fainting spells or seizures
_____ G.E. Reflux
_____ Glaucoma
_____ Hemophilia
_____ Hepatitis, jaundice or liver disease
_____ Recurrent infections
If yes, specify type of infection _____
_____ Kidney problems
_____ Low blood pressure
_____ Lyme disease
_____ Mental health disorders
If yes, specify _____
_____ Malnutrition
_____ Migraines
_____ Night sweats
_____ Neurological disorders
If yes, specify _____
_____ Osteoporosis
_____ Persistent swollen glands in neck
_____ Respiratory problems. If yes, specify
_____ Emphysema
_____ Bronchitis, etc.
_____ Scarlet fever
_____ Severe headaches
_____ Severe or rapid weight loss
_____ Sexually transmitted disease
_____ Sinus trouble
_____ Sleep disorder
_____ Sores or ulcers in the mouth
_____ Stroke
_____ Systemic lupus erythematosus
_____ Thyroid problems
_____ Tuberculosis
_____ Ulcers
_____ Excess urination

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ yes ☐ no
Explanation/Comments: _____

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 other member of his 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:_____

Dear Patient,

One of the most important services we provide is the periodic exam and prophylaxis. During your recare 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_____

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
(PLEASE PRINT)

Date_____

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*