DENTAL INNOVATIONS OF COLUMBUS

Kendra Pavlik DDS **Michelle Bargen DDS**

Date:_____

Patient's Information

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

First Name:_____ Last Name:_____ Middle Initial:_____ Preferred Name:_____

Mailing Address:_____City:_____ State:_____ Zip:_____

Home Phone: (_____)_____-_____ Cellular: (_____)_____-_____ Email:_____

Birth Date:_____/_____/_____ Soc. Sec.: _____-_____-_____Driver Lic #: _____

Student Status ☐Full Time ☐Part Time Name of School:_____ City:_____ State:_____

Employment ☐Full Time ☐Part Time ☐Retired Name of Employer:_____ Phone #:_____

Responsible for Account (If someone other than Patient)

Sex: ☐Male ☐Female

First Name:_____ Last Name:_____ Middle Initial:_____

Mailing Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cellular:_____ Email:_____

Birth Date:_____ Soc. Sec.: _____Driver Lic:_____

Employer:_____ Phone #: (_____)_____Marital Status: ☐Married ☐Single ☐Div. ☐Separated ☐Widowed

Emergency Contact Information (Family Member and Non Family Member)

Name:_____ Relationship:_____ Phone #: (_____)_____-_____

Name:_____ Relationship:_____ Phone #: (_____)_____-_____

Primary Dental Insurance Information

Sex: ☐Male ☐Female Relationship of the Patient: ☐Self ☐Spouse ☐Child ☐Other

Name of Insured:_____ Birth Date:_____/_____/_____ Soc. Sec.: _____-_____-_____

Employer_____ Insurance Company:_____ ID Number:_____

Secondary Dental Insurance Information

Sex: ☐Male ☐Female Relationship of the Patient: ☐Self ☐Spouse ☐Child ☐Other

Name of Insured:_____ Birth Date:_____/_____/_____ Soc. Sec.: _____-_____-_____

Employer_____ Insurance Company:_____ ID Number:_____

Other Information

Who may we Thank for Inviting you to our Practice? _____

(Ex: Family, Friend, Phone Book, Social Media, On-Line Search, Billboard, Mailer, Newspaper, Radio, etc.)

Medical History for _____

Your child's overall health as well as any medication which you child takes could have an important inter-relationship with the dental care you child receives.

Please answer each of the following questions completely.

Is your child under a physician's care now? ☐Yes ☐No-Name and # _____

Has your child ever been hospitalized or had a major operation? ☐Yes ☐No-Year and what for _____

Is your child taking any medications? ☐Yes ☐No
Has your child been seen by a previous dentist? ☐Yes ☐No
When was your last child's last dental visit? _____
Has your child had difficulty with previous dental visits? ☐Yes ☐No
How often does your child brush? _____
How often does your child floss? _____
Is your child's water fluoridated? ☐Yes ☐No
Does your child take a fluoride supplement? ☐Yes ☐No

Med list:

Does your child

Suck thumb/fingers?	☐Yes ☐No	Bite/Chew nails?	☐Yes ☐No
Chew hard objects (pencils, ice, etc.)?	☐Yes ☐No	Grind teeth?	☐Yes ☐No
Restless sleep or chronic tired?	☐Yes ☐No	Trouble paying attention at school?	☐Yes ☐No

Is your child allergic to any of the following?

☐Penicillin ☐Latex ☐ Local Anesthetics ☐Other Please Explain: _____

Do you have, or have you had any of the following?

ADHD/ADD	Yes	No	Convulsions/ Epilepsy	Yes	No	Hepatitis	Yes	No
Acid Reflux	Yes	No	Diabetes	Yes	No	HIV/AIDS	Yes	No
Anemia	Yes	No	Food Allergies	Yes	No	Persistent Cough	Yes	No
Asthma	Yes	No	Handicap/Disabilities	Yes	No	Rheumatic Fever	Yes	No
Blood Transfusion	Yes	No	Hearing Impairment	Yes	No	Stomach, Liver, Kidney Problems	Yes	No
Cancer	Yes	No	Heart Problems	Yes	No	Tuberculosis	Yes	No

Have you ever had any serious illness not listed above? ☐Yes ☐No

If yes, Please explain _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

X_____

Signature of Patient/Guardian if Minor **Date**

Revised 05/2019

HIPPA/ FINANCIAL POLICIES for_____

Contact Information for Protected Health Information

I request that the following directives be adhered to for the disclosure of my Protected Health Information (PHI). This would include my name, diagnosis, x-rays, test results, date of services and financial information.

You may disclose information to my family and/or non-family members listed below:

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

- ☐ You may leave Protected Health Information on my answering machine/voicemail using Phone #:_____
- ☐ You may send me a text message using Phone #:_____
- ☐ You may email me(unencrypted) for dental appointment's. Email address: _____

I accept ☐ decline ☐ a copy of this office's Notice of Privacy Practices.

X_____

Signature of Patient/Guardian if Minor **Date**

DENTAL INNVOATIONS OF COLUMBUS FINANCIAL POLICY

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This Financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our costs to you.

Payment for Service is due at time services are rendered. Our practice accepts **CASH, CHECKS, DEBIT OR CREDIT CARDS**. No interest financing is also available through **CARE CREDIT** to qualified individuals. Returned checks and balances older than 60 days may be subject to collection fees and finance charges at a rate of 1.5% per month (18% annually).
Separated or divorced parents of minors who are responsible for half of the cost of a child's dental care: The parent who brings the child into the dental appointment is responsible for paying the copayment or full fee. If it is necessary, we are happy to hold a Credit/Debit card number from the non-custodial parent on file.

As a courtesy to you, we will be happy to process all of your insurance claims. In order to do this, you must bring proof of your insurance with you to your appointment. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from the date of service, you will be expected to pay the balance in full. Your deductibles and any **estimated** co-payment for treatment is due at the time treatment is provided.

Additionally, our practice will charge $25 for appointments not kept and for appointments that are not rescheduled with at least 24 hours' notice.

Please do not hesitate to ask if you have questions regarding this financial policy. We are committed to providing you with the best experience in dental care.

X_____

Signature of Patient/Guardian if Minor **Date**