# 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 _____

Although dental personal primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. If yes please use the following lines to answer.

Are you under a physician's care now? Yes No-Name and # _____
Have you ever been hospitalized or had a major operation? Yes No-Year and what for _____
Have you ever had a serious head or neck injury? Yes No-Year and what for _____

Are you taking any medications, pills, or drugs? Yes No
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you taking any medication for osteoporosis? Yes No
Are you taking any blood thinners? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No
Do you vape? Yes No

| Med list: |
|---|
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| |
| |
| |
| |

## Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐Other Please Explain: _____

## Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

## Sleep Screening

| | | | | | |
|---|---|---|---|---|---|
| Do you snore? | Yes | No | Are you CPAP intolerant? | Yes | No |
| Do you have unrefreshed sleep or fatigue? | Yes | No | Has someone noticed you stopped breathing? | Yes | No |
| Current CPAP user? | Yes | No | Have you ever had a sleep study? | Yes | No |

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

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Excessive Bleeding | Yes | No | Mitral Valve Prolapse | Yes | No |
| Alzheimer's Disease | Yes | No | Excessive Thirst | Yes | No | Pain in Jaw Joints | Yes | No |
| Anaphylaxis | Yes | No | Fainting Spells/Dizziness | Yes | No | Parathyroid Disease | Yes | No |
| Anemia | Yes | No | Frequent Cough | Yes | No | Psychiatric Care | Yes | No |
| Angina | Yes | No | Frequent Diarrhea | Yes | No | Radiation Treatments | Yes | No |
| Arthritis/Gout | Yes | No | Frequent Headaches | Yes | No | Recent Weight Loss | Yes | No |
| Artificial Heart Valve | Yes | No | Genital Herpes | Yes | No | Renal Dialysis | Yes | No |
| Artificial Joint | Yes | No | Glaucoma | Yes | No | Rheumatic Fever | Yes | No |
| Asthma | Yes | No | Hay Fever | Yes | No | Rheumatism | Yes | No |
| Blood Disease | Yes | No | Heart Attack/Failure | Yes | No | Scarlet Fever | Yes | No |
| Blood Transfusion | Yes | No | Heart Murmur | Yes | No | Shingles | Yes | No |
| Breathing Problem | Yes | No | Heart Pace maker | Yes | No | Sickle Cell Disease | Yes | No |
| Bruise Easily | Yes | No | Heart Trouble/Disease | Yes | No | Sinus Trouble | Yes | No |
| Cancer | Yes | No | Hemophilia | Yes | No | Spina Bifida | Yes | No |
| Chemotherapy | Yes | No | Hepatitis A | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Chest Pains | Yes | No | Hepatitis B or C | Yes | No | Stroke | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Herpes | Yes | No | Swelling of the limbs | Yes | No |
| Congenital Heart Disorder | Yes | No | High Blood Pressure | Yes | No | Thyroid Disease | Yes | No |
| Convulsions | Yes | No | Hives or Rash | Yes | No | Tonsillitis | Yes | No |
| Cortisone Medicine | Yes | No | Hypoglycemia | Yes | No | Tuberculosis | Yes | No |
| Diabetes | Yes | No | Irregular Heartbeat | Yes | No | Tumors or Growths | Yes | No |
| Drug Addiction | Yes | No | Kidney Problems | Yes | No | Ulcers | Yes | No |
| Easily Winded | Yes | No | Leukemia | Yes | No | Venereal Disease | Yes | No |
| Emphysema | Yes | No | Liver Disease | Yes | No | Yellow Jaundice | Yes | No |
| Epilepsy or Seizures | Yes | No | Low Blood Pressure | 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 (or patent's) health. It is my responsibility to inform the dental office of any changes in medical status.

**X**_____

**Signature of Patient/Guardian** **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** **Date**

## DENTAL INNOVATIONS 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** **Date**