



Welcome to Franklinton Dental Group



PATIENT INFORMATION

Date _____
Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ Work Phone _____
State and Zip code _____ Email _____
Birth Date _____ SSN # _____
Circle: Male Female

DENTAL HISTORY

Former Dentist _____ Phone _____
Address _____

Approximate date of last dental appointment _____

Please check (✓) if you have had any problems with the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Clicking or popping of jaw |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Lost filling or crown |
| <input type="checkbox"/> Sensitivity to hot or cold | <input type="checkbox"/> Sores or growth in mouth | |

Have you ever had excessive or prolonged bleeding following a tooth extraction or other injury? Yes ☐ No ☐

Have you ever had trouble associated with previous dental treatment? Yes ☐ No ☐

Have you ever experienced dizziness, fainting, or reaction to the Novocaine? Yes ☐ No ☐

Are you wearing a removable dental appliance? Yes ☐ No ☐
If yes, how old is appliance? _____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Date of last visit _____ Have you had any serious illness or operations? Yes ☐ No ☐

If yes, please specify _____

Are you currently taking any medications? Yes ☐ No ☐

If yes, please list all medications: _____

Do you have any allergies to medicine? Yes ☐ No ☐

If yes, please list all allergies: _____

Women: Are you pregnant? Yes ☐ No ☐

If yes, how many months? _____

Nursing? Yes ☐ No ☐

Taking birth control pills? Yes ☐ No ☐

Please check (✓) if you have had any of the following:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Aids/HIV Positive | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Heart Valve/Joints | <input type="checkbox"/> Herpes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemical Dependent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Murmur | |
| <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Syphilis | |

How did you hear about us? Please specify _____

The information given above is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine the appropriate dental treatment. If there is any change in my medical information, I will inform the dentist.

Patient Signature (Parent or Guardian if minor) _____ Date _____

Doctor's signature _____ Date _____



Franklinton Dental Group

1531 W. Broad St.
Columbus, Oh 43222
(614) 351-0555



INSURANCE INFORMATION

Date _____
Patient Name _____
SSN # _____ Date of Birth _____

Sex: Male _____ Female _____

Marital Status: Single _____ Married _____

Student: Yes _____ No _____

If yes, where do you attend school? _____

Do you have physical or mental disabilities? Yes _____ No _____

Insurance Company _____

Policyholder Name _____ Date of Birth _____

Policyholder Social Security Number _____

Policyholder Employer _____

Employer Address _____

Employer Phone Number _____

Employment Status: Part time _____ Full time _____

Relationship to policyholder: Self _____ Spouse _____ Child _____

Other _____ please specify _____

Emergency Contact (Not living with you):

Name _____

Relation _____

Phone Number _____

As a courtesy to you, our office will bill your insurance company for services rendered. The patient is responsible for any deductible or co pay that applies. The deductible or co pay is due at the time services are rendered. Patient is also responsible for any portion that is not paid by the insurance company. Returned checks will be subject to an additional \$30.00 fee, and patient is responsible for all costs including cost of collection and attorney fees for any unpaid amount.

I understand that ultimately I am responsible for making sure that my bill is paid within 45 days from the time of service, regardless of insurance coverage.

Signature of responsible party _____ Date _____

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact Tom Stevens. You may reach her by:

Practice Name: Jeffrey L. Wilden, D.D.S., Inc.
Telephone Number: (614) 351-0555
Address: 1531 West Broad Street
City, State, Zip: Columbus, Ohio 43222-1043

Patient's Consent

Name: _____

Address: _____

City: _____

Telephone: (_____) _____

Account #: _____

State: _____ Zip: _____

E-mail: _____

Social Security #: _____

I, _____, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____
