Welcome to
The 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:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping of jaw
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Lost filling or crown
- ☐ Sensitivity to hot or cold
- ☐ 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:

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

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**_____

The Dental Group
5478 N. Hamilton Rd.
Columbus, Oh 43230
(614) 939-8338

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. Your 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: _____ State: _____ Zip: _____

Telephone: (_____) _____ E-mail: _____

Account #: _____ 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: _____