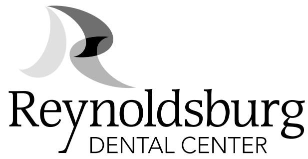



6504 East Main Street . Reynoldsburg, OH 43068 . P: (614) 866-4186 . F: (614) 866-7160 . www.reynoldsburgdentalcenter.com

# PATIENT INFORMATION AND INSURANCE FORM

Name: ______________________________ / Preferred Name ______________ ☐ Male ☐ Female

Address: ______________________________

City: ______________________________ State: __________ Zip: ______________

SSN: ______________________________ DOB: _____/_____ / __________

Home Phone: (______)______________ Work Phone: (______)______________ Cell Phone: (______) ______________

E-mail Address: ______________________________ @ ______________________ .com

Employer: ______________________________

Occupation: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner ☐ Child

**How did you hear about our office?** ☐ Insurance Website ☐ RDC Website ☐ Val Pak ☐ Walk-in/Drive by ☐ Mail Flyer

☐ Newspaper ☐ Google search/what did you search?______________ ☐ Friend/family ______________

☐ Other ______________________________

**Do you prefer to be contacted for appointment confirmation via:** (Please check preference) ☐ E-mail ☐ Phone ☐ Text

**INSURANCE - PRIMARY**

Subscriber Name: ______________________

Relationship to Patient: ______________________

Subscriber DOB: ______________________

Subscriber SSN/ID: ______________________

Subscriber Employer: ______________________

Insurance Company Name: ______________________

Insurance Company Address: ______________________

______________________________

Insurance Company Phone: (_______) ______________

Group Number: ______________________

**INSURANCE – SECONDARY**

Subscriber Name: ______________________

Relationship to Patient: ______________________

Subscriber DOB: ______________________

Subscriber SSN/ID: ______________________

Subscriber Employer: ______________________

Insurance Company Name: ______________________

Insurance Company Address: ______________________

______________________________

Insurance Company Phone: (_______) ______________

Group Number: ______________________

☐ **ASSIGNMENT AND RELEASE** *(Please read carefully and check box)*

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to today's dental 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 payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ______________________________

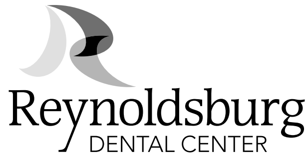
Relationship: ______________________________ Date: ______________

☐ **CONSENT** *(Please check box and sign below):*

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: ______________________________ Date ______________

**PATIENT NAME** ______________________________ **DATE** ______________

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# MEDICAL HISTORY FORM

**Do you have a personal physician?** ☐ Yes ☐ No

Physician's Name: ______________________________

Physician's Phone: (__________) ______________________ Date of last visit: ______________

**Rate your current physical health:** ☐ Good ☐ Fair ☐ Poor

**Are you currently under the care of a physician?** ☐ Yes ☐ No Please explain: ______________________

**Do you use tobacco in any form?** ☐ Yes ☐ No

**Who was your previous dentist?** ______________________________

**When was your last dental cleaning?** ______________ **When was your last dental visit?** ______________

Why did you leave your previous dentist? ______________________________

______________________________

How can we accommodate you better during your dental visit? ______________________________

______________________________

How may we help you today? Is there a specific problem you need to have addressed? Please explain: ______________

______________________________

______________________________

**Emergency Contact:**

Name: ______________________________ Relationship: ______________

Address: ______________________________

City: ______________________________ State: __________ Zip: __________

Home phone: ______________________ Cell Phone: ______________________

☐ ***Please read and check box:***

*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.*

Signature: ______________________________ Date: ______________

☐ ***Please read and check box:***

*I understand that a $25 fee will be added to my account for any appointments canceled without 24 hour notice.*

Signature: ______________________________ Date: ______________

**PATIENT NAME** ______________________________ **DATE** ______________

## MEDICAL HISTORY & CONDITIONS

*(Please check box Yes /No)*

☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N Alcohol Abuse
☐ Y ☐ N Anemia
☐ Y ☐ N Angina Pectoris
☐ Y ☐ N Arthritis
☐ Y ☐ N Artificial Heart Valve
☐ Y ☐ N Asthma
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Cancer
☐ Y ☐ N Colitis
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Diabetes
☐ Y ☐ N Difficulty Breathing/Resp. Disease
☐ Y ☐ N Drug Abuse
☐ Y ☐ N Emphysema
☐ Y ☐ N Epilepsy
☐ Y ☐ N Facial Surgery
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Frequent Headache
☐ Y ☐ N Glaucoma
☐ Y ☐ N HIV+ AIDS
☐ Y ☐ N Heart Attack
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Surgery
☐ Y ☐ N Hemophilia
☐ Y ☐ N Hepatitis A/B/C _____
☐ Y ☐ N Herpes
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Jaundice
☐ Y ☐ N Joint Replacement
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Mitral Valve Prolapse (MVP)
☐ Y ☐ N Nervous Problems
☐ Y ☐ N Pace Maker
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Radiation Therapy
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Seizures
☐ Y ☐ N Sexually Transmitted Disease
☐ Y ☐ N Shingles
☐ Y ☐ N Sickle Cell Disease
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Stroke
☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Tumor or growth on head
☐ Y ☐ N Ulcers

## FEMALES ONLY *(Please check box)*

Are you taking
Birth Control Pills? .......... ☐ Yes ☐ No

Are you pregnant? .......... ☐ Yes ☐ No

If so, number of weeks: ______________

Due Date: ______________

Are you nursing? ........... ☐ Yes ☐ No

## ALLERGIES *(Please check box Yes /No)*

☐ Y ☐ N Aspirin
☐ Y ☐ N Codeine
☐ Y ☐ N Dental Anesthetics
☐ Y ☐ N Erythromycin
☐ Y ☐ N Jewelry
☐ Y ☐ N Latex
☐ Y ☐ N Sulfa
☐ Y ☐ N Penicillin
☐ Y ☐ N Tetracycline
☐ Y ☐ N Other______________

**Are you taking any medications (including over-the-counter)?** ....... ☐ Yes ☐ No

Please list each one:

______________________________
______________________________
______________________________
______________________________

**Do you take any of the following medications (blood thinners)?**
☐ Aspirin ☐ Plavix ☐ Coumadin
☐ Other blood thinner

**Do you require antibiotic premedication prior to dental treatment?** ............... ☐ Yes ☐ No
*(Heart conditions and joint replacement require antibiotic premedication)*

**Are you currently taking any medication for osteoporosis or weak bones?** ........... ☐ Yes ☐ No

**Any hospitalization in the last 6 months?** ...... ☐ Yes ☐ No

Please explain: ______________________________
______________________________

## DENTAL SERVICES & TREATMENTS

How would you rate your current dental health? . . . ☐ Good ☐ Fair ☐ Poor

Are you currently in pain? . . . ☐ Yes ☐ No

Have you ever had gum treatment? ................. ☐ Yes ☐ No

Do you now or have you had any pain/ discomfort in your jaw joint? ☐ Yes ☐ No

Do you have sleep apnea? . . ☐ Yes ☐ No

Do you snore? ............. ☐ Yes ☐ No

Are you under stress? ...... ☐ Yes ☐ No

Do you like your smile? ..... ☐ Yes ☐ No

Is there anything you would like to change about your smile? . . ☐ Yes ☐ No

Are you happy with the color of your teeth? ................ ☐ Yes ☐ No

Do your gums bleed? ....... ☐ Yes ☐ No

How many times do you:
brush/day?_______ floss/week?_________

Are your teeth sensitive to heat, cold or anything else? .............. ☐ Yes ☐ No

Have you ever had a serious or a difficult problem with any previous dental work? ............... ☐ Yes ☐ No

**Updates**:

______________________________
______________________________
______________________________
______________________________
______________________________

**Reynoldsburg Dental Center**
**William J. Lenz, D.D.S.** and **John K. Rosen, D.D.S.**
**6504 East Main St.**
**Reynoldsburg, OH 43068**
**(614) 866-4186**

# Financial Agreement

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of **estimated** patient portion is due at the time of treatment. We strive to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1. Cash, Check, or Visa, MasterCard and Discover

2. Flexible payment plans of up to 18 months upon approval with Care Credit®. Approval must be received prior to treatment date.

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans may not correspond to individual patient needs, and as such, some routine and necessary dental services may not be covered even though you may need those services.

**Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility**. We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in **estimating** your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is processed.

**I realize I am financially responsible for all charges incurred, regardless of insurance coverage.** All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

**Returned Checks** – A fee of $30 will be charged for any returned checks.

**Minor Patients** – The adult accompanying the minor is responsible for the payment on the account at the time of service.

By signing this form I authorize Reynoldsburg Dental Center to process **credit card transactions** initiated by me either by mail or phone.

I have read and fully understand my financial options and obligations.

_______________________________________________ _________________________

**Signature of Patient and/or Legal Guardian** **Date**

Reynoldsburg Dental Center

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

_____________________________________
{Please 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________