Medical/Dental Health History -

Today's Date _____

Patient Name _____ DOB: _____
Last First MI

MEDICAL HISTORY

Primary Care Physician's Name _____
Phone_____
Have you had any serious illnesses or operations? YES / NO
If yes, explain _____
Have you ever had a blood transfusion? YES / NO
If yes, give approximate dates _____

(Women) Are you pregnant? YES / NO Nursing? YES / NO Taking oral contraceptives? YES / NO

Check (✓) if you have or have had any of the following:

- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
  Explain:
  _____
- ☐ Asthma
- ☐ Benadryl
- ☐ Beta Blockers
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive/AIDS
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease or COPD
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Anxiety
- ☐ Osteoporosis
- ☐ Pain in Jaw Joint
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Yellow Jaundice
- ☐ Do you use tobacco products?
  _____

☐ Other _____

Are you allergic to any medications or substances?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Metal ☐ Penicillin ☐ Sulfa
☐ Other _____

Please list ALL medications or supplements you are currently taking: _____

_____

DENTAL HISTORY

Check (✓) if you have experienced problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clenching/Grinding of teeth
- ☐ Clicking or popping of jaw
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal disease/treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you brush? _____ How often do you floss? _____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X_____ **Date** _____

Patient Signature (Parent/Guardian if Minor)

COLUMBUS FAMILY DENTISTRY

Dr. Scott Johnson, D.D.S

Patient Registration –

Patient Name_____

Mailing Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email _____

Birth Date ____/____/____ Age _____ SSN _____ Sex: Male Female

Marital Status: Single Married Widowed Divorced Spouse's Name _____

Dental Insurance Information –

Primary Insurance _____ **Secondary** Insurance _____

Employer _____ Employer _____

Subscriber's Name _____ Subscriber's Name _____

ID # or SSN _____ ID # or SSN _____

Birth Date ____/____/____ Group # _____ Birth Date ____/____/____ Group # _____

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

Insurance Policy –

We are committed to helping you maximize your insurance benefits. Insurance policies vary greatly, and we can only estimate your coverage. **Your estimated portion is expected at the time of service.** As a service to our patients, we will bill your insurance company for services, and allow them 30 days to render payment. After 31 days, you are responsible for the entire bill, to be paid in full.

Responsible Party –

Name _____ Relationship to Patient _____

Mailing Address _____ Cell Phone _____

City _____ State _____ Zip _____

Patient Signature (Parent/Guardian if Minor):_____ **Date:**_____

HIPAA Privacy Permission –

By signing this form, I give Columbus Family Dentistry permission to disclose my Protected Health Information to the individual listed below. **The individual I designate will be my emergency contact**** The information that Columbus Family Dentistry may disclose is limited to the information directly related to that person's involvement in my dental care or payment of my dental care.

**_____ (___)_____ _____

(Name of my emergency contact) **Phone number** **Relationship to you**

Appointment Policy –

Our office makes every effort to remain on schedule throughout the day. We value your time and will do our best to keep you from having to wait. Our office reserves appointments for patients according to their needs. Each person is an individual, and some may require more "tender loving care" than others. We ask for your patience, keeping in mind that you may be the next one needing our extra attention.

As a courtesy, our office will attempt to contact you for confirmation 1-2 days before your appointment, however, we do ask that our patients/parents assume responsibility for your appointment time. Broken appointments, or short-term cancellations, (within 24 hours) without proper notification can be costly to our office, and unfair to other patients, who need appointments. In recent years Columbus Family Dentistry has seen an increase in cancellations and broken appointments without proper notice**. Therefore, if you cancel without ample notification or fail to show up to your scheduled appointment, a $25.00 fee will be assessed to your account.**

Photo / Video Consent –

I authorize Columbus Family Dentistry to take photographs of my face, jaws, and teeth.

I understand that the photographs and/or videos will be used as a record of my treatment and care. They may also be used for demonstrations to other dentists and patients, as well as "before and after" pictures for our website and advertisements.

Patient Signature (Parent/Guardian if Minor):_____ Date:_____