COLUMBUS DENTAL CARE PLLC

Patient Registration Form

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Email: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Emergency Contact _____

Emerg. #: _____

Referral By: _____

Ins. Member ID#: _____

Ins. Group #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

COLUMBUS DENTAL CARE PLLC

Patient Medical History

Patient Name: _____ Birth Date: _____ Date Created: _____

Although dental personnel 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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Primary Physicians Name and Address below:

Are there any concerns or changes you would like to make with your teeth?	◯ Yes ◯ No	If yes	
Do you need to be premedicated for Dental visits?	◯ Yes ◯ No	If yes	
Have you been hospitalized or had any surgery?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Do you use tobacco?	◯ Yes ◯ No	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	
Do you take a daily asprin?	◯ Yes ◯ No	If yes	
Are you taking any medications or supplements? Please list all medications and supplements:	◯ Yes ◯ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other Allergies? ◯ Yes ◯ No If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No
Hepatitis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Arthritis ◯ Yes ◯ No
Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No
Stroke ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No
Tonsillitis ◯ Yes ◯ No	Heart Attack ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Heart Pacemaker ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Heart Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No
Autoimmune Disease ◯ Yes ◯ No			

Do you have any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Columbus Dental Care PLLC

HIPAA Notice of Privacy Practices;
Office Financial and Dental Insurance Policy; Patient Consent for Services

Patient Name:_____

Date: _____

HIPAA Notice of Privacy Practices

Columbus Dental Care PLLC is required by law to maintain the privacy of your dental information and provide patients with our HIPAA - Notice of Privacy Practices. This form is a notice of our legal duties and privacy practices with respect to your Public Health Information.

The signature below acknowledges receipt of a copy of the HIPAA Notice of Privacy Practices, and grants to clerical/clinical staff permission to release health and/or financial information to a family member, friend or other person to the extent necessary to help with your healthcare, or payment of your healthcare, unless otherwise noted.

List person(s) NOT ALLOWED ACCESS to your health or financial records on the line below:

_____

Office Financial and Dental Insurance Policy

All patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and *patients are personally responsible for payment of all dental services.* Columbus Dental Care PLLC will help prepare the patient insurance forms and/or assist in making collections from insurance companies, and will credit any such collections to the patient's account.

Fees generated by Columbus Dental Care PLLC providers are not governed by the provisions of patient insurance policies. Our office is not responsible for collecting your insurance payment or negotiating settlements on disputed claims. Each patient - *not the insurance company* - is responsible for payment of their bill. Patient payment is due at time of service.

I authorize the release of any dental information necessary to process claims for services provided; and authorize payment of dental benefits to Dr. Joseph Columbus and Dr. Dori Lang Columbus.

The signature below acknowledges receipt of a copy of the Office Financial and Dental Insurance Policy and agreement with its content.

Consent for Services

I hereby voluntarily consent to dental treatment as deemed necessary by the doctors of Columbus Dental Care PLLC.

I understand that it is a policy of the practice to contact patients by phone, mail and/or email to remind them of appointments. I grant permission to Columbus Dental Care PLLC to telephone me, at any number provided, to discuss matters related to my treatment.

The signature below acknowledges consent for services provided by Columbus Dental Care PLLC providers.

X _____

Patient Signature (or parent/guardian if patient is a minor)