



**COLUMBIA
DENTAL**

We Welcome You

Thank you for choosing Columbia Dental. In order to properly serve you, we need the following information. Please print all information. This information is Confidential.

Today's Date / /
Please Print

1 Patient Information

Please Print

Patient Name _____ Sex M F Age _____ Birth Date _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____ Soc Sec # _____

Email Address _____ Employer (Patient's or Parent/Guardian's) _____

Business Address _____ City _____ State _____ Zip Code _____

Check box: Minor Single Married Divorced Widowed

Person To Contact In Case Of Emergency? _____
(Not at the same address as patient) Phone # _____

Physician Name _____ Referring Dentist's Name _____

Patient's Other Dental Specialists (If Any) _____ Reason For Visit Here _____

Are you (the patient) currently a patient of Columbia Dental? Yes No

How did you hear of us? Newspaper _____ Radio _____ TV _____ Other _____
Name Name Name

2 Person Responsible for Payment Check box if same as above

Please Print

Name of Person Responsible For Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Soc Sec # _____

Birth Date _____ Drivers License # _____ Employer _____

3 Insurance Information

Please Print

Name of Insured _____ Relationship to Patient _____

Name of Employer _____

Employer's Address _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____ Soc Sec # or Insurance # _____ Union or Local # _____

Continues onto other side

4 Important Information About Your Insurance

The treatment estimate you may be about to receive will be based on dental insurance information provided to us on your behalf. This information does not constitute or guarantee insurance payment. Many plans find it difficult to accurately estimate treatment co-pays despite our best efforts to gather the correct information.

If you wish to have a guarantee of insurance payment, we would be glad to forward your proposed treatment plan, x-rays, and other documentation to your insurance company for their review.

This is the most accurate and dependable way to determine benefits. Please be advised, however, this procedure can take approximately four (4) to six (6) weeks. That is the time insurance companies often take to respond to questions regarding payment of claims.

We appreciate your confidence in our office and our staff.

I have read and understand what has been explained to me regarding insurance coverage.

Patient Name _____
Date

Columbia Dental Staff Member Name _____
Date

5 Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996, (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, Plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain Payment From Third Party Payers
- Conduct Normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health appreciation. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at anytime at the address above to obtain a current copy of the Notice Of Privacy Practices.

The complete description is in the binder located under the coffee table in the reception room. (Please feel free to review and/or obtain a personal copy by asking the front desk.)

I understand that I may request that you restrict how my private information is to be used or disclosed to carry our treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Printed) _____
Relationship to Patient:

Signature of Patient or Parent/Guardian If Minor: _____
Date:



Health History

Please print all information. This information is Confidential.
Please fill out this form completely in ink. If you have any questions or need assistance, please ask us – We Will Be Happy To Help.

Today's Date / /
Please Print

Patient's Name: _____

6 Patient Health History

Please Print

Please Answer ALL QUESTIONS by CIRCLING yes (Y) or no (N)

- 1. Are you in good health? Y or N
- 2. Has there been any change in your general health in the past year?..... Y or N
- 3. Date of last physical exam? _____
- 4. Are you now under a physician's care for a particular problem? Y or N
- 5. Have you ever had any serious illnesses, operations, or hospitalizations? Y or N

If so describe _____

6. Have you had any adverse effects from dental treatment? Y or N

Do you have or have you ever had: (Answer ALL questions and circle your specific condition when applicable)

- A. Rheumatic Fever or Rheumatic Heart Disease? Y or N
- B. Congenital Heart Disease? Y or N
- C. Cardiovascular Disease (Heart Trouble, Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery and Pace Maker)? Y or N
- D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness Of Breath, Chest Pain, Severe Coughing)? Y or N
- E. Seizures, Convulsions, Epilepsy, Fainting, Psychiatric Treatment, Dizziness, Nervous Disorder or Breakdown? Y or N
- F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Do you bruise easily? Y or N
- G. Liver Disease (Jaundice, Hepatitis) Y or N
- H. Kidney Disease? Y or N
- I. Diabetes? Y or N
- J. Thyroid Disease (Goiter)? Y or N
- K. Arthritis? Y or N
- L. Stomach Ulcers or Colitis? Y or N
- M. Glaucoma? Y or N
- N. Frequent or Recurring Mouth Sores? Y or N
- O. Implants placed anywhere in your body? (Heart Valve, Hip, Knee) Y or N
- P. Radiation (X-Ray) Treatment for Cancer? Y or N
- Q. Clicking or Popping of Jaw Joint, Pain Near Ear, Difficulty Opening Mouth, Grind or Clench Teeth? Y or N
- R. Sinus or Nasal Problems? (Y) or (N)
- S. Any Disease, Drugs or Transplant Operation that has depressed your Immune System? Y or N
- T. Recurrent Infections of any kind? Y or N

Continues onto other side

7. Are you using or taking any of the following: (Answer ALL questions and circle the specific medication when applicable)

- A. Tagamet? **Y** or **N**
 B. Thyroid Medications? **Y** or **N**
 C. Antibiotics and Sulfa Drugs? **Y** or **N**
 D. Anticoagulants (Blood Thinners)? **Y** or **N**
 E. High Blood Pressure Medicine? **Y** or **N**
 F. Steroids (Cortisone, ETC) **Y** or **N**
 G. Tranquilizers (Valium, Etc) **Y** or **N**
 H. Insulin, Diabinese, or Similar Drug? **Y** or **N**
 I. Digitalis, Inderal, Nitroglycerin, Calcium Channel Blockers,
 Procardia or Other Heart Medicines? **Y** or **N**
 J. Aspirin or Ibuprofen (Motrin, Naprosyn, Etc)? **Y** or **N**
 How much daily? _____
 K. Marijuana or other "Street Drugs" **Y** or **N**
 L. Antihistamines or Decongestants (Seldane) **Y** or **N**
 M. Are you taking any other Medications, Pills or Drugs? **Y** or **N**

If yes please list _____

8. Are you allergic or have a bad reaction to: (Answer ALL questions and circle the specific medication when applicable)

- A. Local Anesthetic (Novocain, Etc)? **Y** or **N**
 B. Penicillin, Amoxicillin, Cephalosporins, or Other Antibiotics? **Y** or **N**
 C. Barbiturates, Sedatives, Etc? **Y** or **N**
 D. Aspirin, or Ibuprofen? **Y** or **N**
 E. Codeine or Other Pain Killers? **Y** or **N**
 F. Latex or Rubber Products? **Y** or **N**
 G. Other Allergies or Reactions? **Y** or **N**

If yes please list _____

9. Do you smoke or chew tobacco? Y or N

10. Do you use alcohol? Y or N

11. FOR WOMEN ONLY

- A. If you are using Oral Contraceptives it is important that you understand that antibiotics and other medications **may interfere with the effectiveness of oral contraceptives**. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your physician for further guidance.
- B. If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first Trimester. Please advise your doctor if there is any chance of your being pregnant!
- C. Do you wish to have a Pregnancy Test? **Y** or **N**

12. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y or N

13. Do you wish to talk to the doctor privately about anything? Y or N

7**Signatures Required**

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Signature Of Person Completing Health History

Doctor's Initials

Medical Update: *I have read my Health History dated ___/___/___/ and confirm that it adequately states past and present conditions.*

Date

Exceptions Or Changes

Patient's Signature

Doctors Initials

Date

Exceptions Or Changes

Patient's Signature

Doctors Initials