COLUMBUS FAMILY DENTAL

Personal Information

Name: _____

I prefer to be called:_____

❒ Single ❒ Married ❒ Divorced ❒ Widowed

❒ Male ❒ Female

Birthday: _____/_____/_____ Age: _____

SSN: _____-_____-_____

Street Address: _____

Apt: _____ City/State/Zip: _____

Home Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Email: _____

Employer: _____

Occupation: _____

Work Phone: (_____) _____-_____

How did you hear about us? _____

If referred, whom may we thank? _____

Parent's Information

Mother ❒ Step Mother ❒ Guardian

Name: _____ Birthday: _____

Home/Cell:_____ Work: _____

Employer: _____

SSN: _____-_____-_____

Father ❒ Step Father ❒ Guardian

Name: _____ Birthday: _____

Home/Cell:_____ Work: _____

Employer: _____

SSN: _____-_____-_____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Member ID: _____

Group #: _____

Insured's Name: _____

Insured's Birthday: _____/_____/_____

Insured's SSN: _____-_____-_____

Insured's Employer: _____

Medical Insurance: _____

Spouse Information

Name: _____

Employer: _____

Home/Cell:_____ Work: _____

Birthday: _____/_____/_____ Age: _____

Dental History

Who was your previous Dentist? _____

When was your last dental visit? _____

When were you last dental xrays taken? _____

Are you currently sensitive or in pain? _____

Do you like your smile? _____

How many times a day do you brush? _____

How many times a week do you floss? _____

I understand that I am responsible for payment of services rendered and also responsible for any copayment and deductibles that my insurance does not cover. If my bill is placed in the hands of an attorney or collection agency for purposes of collection after default, I promise to pay all reasonable attorney's fees and all other reasonable collection fees incurred. Furthermore, if a suit is instituted to enforce collection on my bill, I promise to pay all court costs associated with said legal action.

Our office policy is payment in full day of service. A 5% discount is offered for cash, check or credit card payments. We accept Mastercard and Visa. We also offer third party, no interest payment plans.

SIGNATURE	**DATE**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Medical History

Although dental personnel primarily treat your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Have you been informed to take a pre-medication before a dental appointment? ☐ Yes ☐ No
Are you under a physician's care now? ☐ Yes ☐ No
If yes, please explain: _____
Physician's Name: _____ *Phone #:* _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If yes, please explain: _____
Are you taking any medications, pills or drugs? ☐ Yes ☐ No
If yes, please list: _____
_____
Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No
Have you ever taken any medications containing bisphosphonates? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
If yes, please list: _____

Women Only: Are you: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?
Due Date: _____

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal
☐ Sulfa Drugs ☐ Tetracycline ☐ Local anesthetics ☐ Acrylics ☐ Others: _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Yellow Jaundice
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

Have you ever had any serious illness not listed above? ☐ Yes ☐ No
If yes, please explain: _____

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: _____ **Date:** _____