PATIENT INFORMATION

Name: _______________________________________Preferred Name: ______________ Today's date: _____________

Birthday: ____________________ Age: _______ Sex: __M __F Social Security Number: _________________

Address: _______________________________________ City: ________________ State: _______ Zip: ___________

Home phone (_____) ______________ Cell phone (_____) ________________ Work phone (_____) ________________

Email: __________________________________

How would you like to be contacted: __________________________

Marital Status: __________________ Employer: _______________________ Occupation: ________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? Please be specific ____

Emergency contact: ________________________ Relationship: _____________________ Phone: __________________

Responsible Party

__same as above

Person Responsible for Account: __________________________________ Relationship to patient: _________________

Birthday: _____________________ Social Security Number: ___________________ Employer: ____________________

Address: ____ City: _______________ State: ________ Zip: ___________

Home phone (_____) ______________ Cell phone (_____) ________________ Work phone (_____) ________________

Insurance Information

Name of Insured: ____ Relationship to patient: _______________________

Birthdate: __________________ Social Security Number: _________________ Employer: ________________________

Insurance Company: ____________________________________ Group #: ___________________________________

Insurance Company Address: ____

MEDICAL HISTORY

PATIENT NAME ____**BIRTH DATE** ____________________________________

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.

Are you under a specialists care now?	Y	N	If yes, please explain:____________________________
Have you ever been hospitalized or had a major operation?	Y	N	If yes, please explain: ___________________________
Have you ever had a serious head or neck injury?	Y	N	If yes, please explain: ___________________________
Are you taking any medications, pills, or drugs?	Y	N	If yes, please explain: ___________________________
Do you use tobacco?	Y	N	
Do you need to pre-medicate?	Y	N	

Women: Are you		
Pregnant/Trying to get pregnant?	Y	N
Taking oral contraceptives?	Y	N
Nursing?	Y	N

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic	Metal	Latex	Sulfa Drugs	Local Anesthetics

Other Allergies	Y	N	If yes, please list them:

Do you use controlled substances?	Y	N	If yes, please explain:

Current Medical Conditions

Acid Reflux	Y	N	AIDS/HIV Positive	Y	N	Alzheimer's Disease	Y	N	Anaphylaxis	Y	N
Anemia	Y	N	Angina	Y	N	Arthritis/Gout	Y	N	Artificial Heart Valve	Y	N
Artificial Joint/Which Joint/When?	Y	N	Asthma	Y	N	Breathing Problems	Y	N	Bruise Easily	Y	N
Cancer	Y	N	Chemotherapy	Y	N	Chest Pains	Y	N	Cold Sores/Fever Blisters	Y	N
Congenital Heart Disorder	Y	N	Convulsions	Y	N	Diabetes	Y	N	Drug Addiction	Y	N
Dry Mouth	Y	N	Epilepsy or Seizures	Y	N	Excessive Bleeding	Y	N	Fainting Spells/Dizziness	Y	N
Frequent Cough	Y	N	Frequent Diarrhea	Y	N	Frequent Headaches	Y	N	Glaucoma	Y	N
Hay Fever	Y	N	Heart Attack/Failure	Y	N	Heart Murmur	Y	N	Heart Pacemaker	Y	N
Heart Trouble/Disease	Y	N	Hemophilia	Y	N	Hepatitis A	Y	N	Hepatitis B or C	Y	N
Herpes	Y	N	High Blood Pressure	Y	N	High Cholesterol	Y	N	Hives or Rash	Y	N
HPV	Y	N	Inflammatory Disease/Type	Y	N	Kidney Problems	Y	N	Leukemia	Y	N
Liver Disease	Y	N	Low Blood Pressure	Y	N	Lung Disease	Y	N	Mitral Valve Prolapse	Y	N
Osteoporosis	Y	N	Pain in Jaw Joints	Y	N	Parathyroid Disease	Y	N	Psychiatric Care	Y	N
Radiation Treatment	Y	N	Renal Dialysis	Y	N	Rheumatic Fever	Y	N	Scarlet Fever	Y	N
Shingles	Y	N	Sickle Cell Disease	Y	N	Sleep Apnea	Y	N	Stomach/Intestinal Disease	Y	N
Stroke	Y	N	Thyroid Disease	Y	N	Tonsillitis	Y	N	Tuberculosis	Y	N
Tumor or Growths	Y	N	Ulcers	Y	N	Venereal Disease	Y	N	Yellow Jaundice	Y	N

Have you been diagnosed with any of the previous conditions in the past? Please include details.	Y	N	If yes, please explain:
Has any of your immediate family been diagnosed with any of the previous conditions?	Y	N	If yes, please explain:
Have you ever had any serious illness not listed above?	Y	N	If yes, please explain:

Additional Questions

Check if you have had any problems with any of the following:

Bad Breath	☐	Loose teeth or broken fillings	☐	Periodontal Treatment	☐
Grinding Teeth	☐	Sensitivity to sweets	☐	Food collection between teeth	☐
Sensitivity to hot	☐	Sensitivity to cold	☐	Pain	☐
Bleeding Gums	☐	Sensitivity when biting	☐	Sores or growths in mouth	☐

Would you be interested in straighter teeth?	Y	N
Whiter teeth?	Y	N
Reducing snoring?	Y	N

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 ______________________

HIPAA - ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

PATIENT NAME ____**BIRTH DATE** ____________________________________

We at Arlington Dental Group are required by law to maintain the privacy of and provide individuals with the Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with a member of the practice in person or by phone. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

____ ________________

Signature of patient or patient's representative/parent Date

____ ________________

Printed name of patient or patient's representative/parent Date

____

Relationship to patient

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our privacy practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited the acknowledgement
- ○ Other (please specify)

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FINANCIAL AGREEMENT

At Arlington Dental Group, we want all of our guests to be able to comfortably afford dental care. We proudly offer the following financial policy so that our guests have the opportunity to decide which payment option is best for their needs.

Insurance

Your insurance is a contract between you, your employer, and your insurance company. Arlington Dental Group will gladly work with you to help you get the maximum benefit available to you. Most insurance plans do not cover 100% of the treatment cost. We will ESTIMATE your coverage as closely as possible, but can make no guarantees as to what your insurance will pay. We understand that dental benefits are important to our guests. We ask for payment at time of treatment. We will then promptly file and follow up on your dental claims to ensure that you receive the correct maximum benefits. We offer several payment options for your portion of diagnosed treatment so that your care is not compromised due to financial concerns.

Payment Options

- Cash or Check
- Mastercard, Visa, Discover, or American Express
- Care Credit: A healthcare credit card that can be used for your dental and health care needs.
- Unfortunately we are unable to accept 3rd party endorsed checks.

Our Appointment Agreement

Because we reserve time specifically for you and your dental treatment, it is vital that we receive appropriate notice for cancellations. If you find that you are unable to keep an appointment, we kindly ask 2 business days' notice when rescheduling an appointment. **Appointments not cancelled within 2 business days, or no-show appointments will be charged a $40 fee.**

Initial: ______________________________

Financial Responsibility

I understand that payment is due at the time of service unless prior arrangements have been made. I understand that my insurance may cover a portion of the treatment; however, I am ultimately responsible for any balance on my account for services rendered.

I have read and fully understand the financial policies of this office.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____

DATE ______________________

3360 Tremont Rd. Suite 100
Upper Arlington, OH 43221
614.451.7377