Bethel Dental Care

Sarah Zarick D.D.S
1151 Bethel Rd. Suite 203 Columbus, OH 43220 | 614-451-0341 | info@betheldentalcare.com

Patient Information

About You:

Patient name: _____ Date of birth: _____ Sex: ❑ Male ❑ Female Age: _____

I prefer to be called: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

How did you hear about us?: ❑ Insurance Website ❑ Google/Internet Search ❑ Radio ❑ TV ❑ Print

❑ Referred by friend/family/etc, please let us know their name so we can thank them: _____

Dental Insurance:

❑ Not covered by dental insurance (you may skip this section)

Primary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: ___ / ___ / ___ SS #/Member ID: _____

If this insurance is through an employer, Employer Name: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: ___ / ___ / ___ SS #/Member ID: _____

If this insurance is through an employer, Employer Name: _____

Dental Health History:

Reason for today's visit:_____

Are you currently in pain? ❑ yes ❑ no

Former Dentist:_____ City/State _____

Date of last dentist visit: ___ / ___ / ____ Date of last dental x-rays: __ / ___ / ___

How would you describe your overall dental health?
❑ Good ❑ Fair ❑ Poor

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Chew on one side of mouth
- ❑ Clicking or popping jaw
- ❑ Dental anxiety
- ❑ Dry mouth
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Gums swollen or tender
- ❑ Jaw pain or tiredness
- ❑ Lip or cheek biting
- ❑ Loose teeth or broken fillings
- ❑ Mouth pain, brushing
- ❑ Orthodontic treatment
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

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Date: ___ / ___ / ___ Comments: _____ Initials: _____

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Patient Information (continued)

Medical Health History

Physician's Name:_____ City/State _____

How would you describe your overall health?
❑ Good ❑ Fair ❑ Poor

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco: ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking or have you taken any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Fosamax, or any other bisphophonate
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Phen-Fen
- ❑ Other:_____
  _____

Women:

- ❑ Taking hormones or contraceptives
- ❑ Pregnant: Week # _____
- ❑ Nursing

Do you have any disease, condition, or problem not listed above? _____

_____

Please add anything else you would like us to know about: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during the diagnosis and treatment with my informed consent.

Signature of patient (or parent/guardian): _____ Date: ___ / ___ / ____

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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 physician certifications.

My signature below indicates that I am aware that Bethel Dental Care is HIPAA compliant and that I may request a copy of the *Notice of Privacy Practices* at any time. 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 any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care 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 or Parent/Guardian: _____

Relationship to Patient (if not patient): _____

Signature: _____

Date: ___ / ___ / ___

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Financial and Missed Appointment Policies

We accept cash, checks, Visa, MasterCard and Discover.

As a courtesy to our patients with insurance, we will file your insurance claims for you. Deductibles and Co-Payments are due at the time that services are rendered. We make every effort to give you an accurate estimate of what your portion owed will be. Please remember that the contract is between you and your insurance company. Any remaining balance is your responsibility. Disputes regarding reimbursement are between you and your insurance carrier.

If you must reschedule an appointment, please provide 24 hours notice. This courtesy makes it possible to give your reserved time to another patient in need of care. The office will allow three (3) no show or same day cancellations. After that, we will provide emergency care only for 30 days to allow you time to find a new dentist.

By signing below you acknowledge that you have read and understand our financial and appointment policies.

Signature of patient (or parent/guardian): _____

Date: ___ / ___ / ____

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