dentalfacultypractice
at The Ohio State University

For Office Use Only:

EMR #: _____

Patient Registration

Please complete registration in its entirety. Have your insurance cards and driver's license available for scanning purposes.

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐

PATIENT NAME _____
Last First Middle Maiden

PREFERRED NAME _____ BIRTH DATE (Month/Date/Year) _____

MALE ☐ FEMALE ☐ PATIENT'S S.S.# _____

PRIMARY LANGUAGE: _____ DO YOU NEED AN INTERPRETER? ☐ Yes ☐ No

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER _____

HOME ADDRESS _____ APT NO. _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

WORK PHONE (_____) _____ PREFERRED CONTACT # ☐ Home ☐ Cell ☐ Work

EMAIL ADDRESS _____ MAY WE EMAIL YOU? ☐ Yes ☐ No

STUDENT ☐ Yes ☐ No WHERE ? _____ ☐ Full Time ☐ Part Time

OSU STUDENT I.D. # (if applicable): _____ DRIVER'S LICENSE #: _____

PATIENT'S EMPLOYER _____ MAY YOU BE CONTACTED AT WORK? ☐ Yes ☐ No

OSU EMPLOYEE I.D. # (if applicable) _____

EMERGENCY CONTACT

Name: _____

Relationship to patient: _____ Phone: _____

PRIMARY CARE PHYSICIAN _____
First Name Last Name Telephone Number

PHARMACY NAME/LOCATION _____ _____
Telephone Number

Do you have family members who are patients of our practice? ☐ Yes ☐ No

If yes, name of patient(s) _____

_____

_____

Patient Signature: _____ Date: _____
If patient is a minor, parent's signature

Insurance Information

Please complete all applicable information and have your insurance card(s) available for our office to scan.

Primary Dental Insurance ☐ **I DO NOT HAVE DENTAL INSURANCE AT THIS TIME**

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: ○Self ○Spouse ○Parent ○Guardian Subscriber Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Divorced ○Other_____Subscriber address same as patient's ○Yes ○No

Secondary Dental Insurance ☐ **I DO NOT HAVE SECONDARY DENTAL COVERAGE**

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: ○Self ○Spouse ○Parent ○Guardian Subscriber Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Divorced ○Other_____Subscriber address same as patient's ○Yes ○No

Subscriber's address if different than patient's:_____

COMPLETE THIS SECTION IF YOUR VISIT IS MEDICAL IN NATURE. Otherwise, please skip to Adult Medical History.
Medical visit examples: oral surgery, oral pathology, or related to an accident.

Primary Medical Insurance ☐ **I DO NOT HAVE MEDICAL COVERAGE AT THIS TIME**

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: ○Self ○Spouse ○Parent ○Guardian Subscriber Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Divorced ○Other_____Subscriber address same as patient's ○Yes ○No

Secondary Medical Insurance ☐ **I DO NOT HAVE SECONDARY MEDICAL COVERAGE**

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber Birth Date	
Insurance P.O. Box		Subscriber S.S. #	
Employer Name		Identification #	
Employer Tel. #		Group #	

Relationship to patient: ○Self ○Spouse ○Parent ○Guardian Subscriber Sex: ○Male ○Female

Marital Status: ○Single ○Married ○Divorced ○Other_____Subscriber address same as patient's ○Yes ○No

Subscriber's address if different than patient's:_____

END OF MEDICAL SECTION

For Office Use Only:

EMR #: _____

Child Medical History

Patient Name: _____ Date of Birth _____ Today's Date _____
First *M.I.* *Last.*

Please mark YES or NO

Y	N	GENERAL
		Height _____ft_____in
		Weight _____lbs
		General health status (choose one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐	☐	Is your child/adolescent under a physician's care?
☐	☐	Has your child/adolescent ever been hospitalized?
☐	☐	Has your child/adolescent had any emergency room visits?
☐	☐	Has a doctor limited activities for your child/Adolescent?
☐	☐	Can your child/adolescent climb two flights of stairs without resting?

Please answer "yes" or "no" for any conditions that you have now, or have had in the past

Y	N	CARDIOVASCULAR / HEMATOLOGIC
☐	☐	Does your child/adolescent have any heart or blood conditions?
☐	☐	History of heart problems or heart murmur
☐	☐	Bleeding or clotting conditions
☐	☐	Sickle cell anemia or trait

Y	N	PULMONARY / BREATHING
☐	☐	Does your child/adolescent have any lung or breathing conditions?
☐	☐	Seasonal stress or exercise induced allergies or hay fever
☐	☐	Asthma or wheezing
☐	☐	Snoring, interrupted breathing, sleep apnea
☐	☐	Other lung or breathing conditions

Y	N	HEAD / EYES / EARS / NOSE / THROAT
☐	☐	Does your child/adolescent have any head, eye, ear, nose, or throat conditions?
☐	☐	Frequent sinus infections (sinusitis)
☐	☐	Frequent ear or hearing problems
☐	☐	Vision conditions
☐	☐	Frequent sore throat

Y	N	NERVOUS SYSTEM
☐	☐	Does your child/adolescent have any nervous system conditions?
☐	☐	Epilepsy or seizure disorder - **if yes**, please choose which type: ☐ Absence ☐ Grand mal ☐ Petit mal ☐ Other

Y	N	GASTROINTESTINAL / LIVER / BLOOD / METABOLIC
☐	☐	Does your child/adolescent have any gastrointestinal, liver, blood or metabolic conditions?
☐	☐	Hepatitis or other liver conditions
☐	☐	Diabetes - **if yes**, please choose which type: ☐ **I** ☐ **II**
☐	☐	Thyroid disease
☐	☐	Kidney conditions
☐	☐	Gastrointestinal esophageal reflux disease (GERD)
☐	☐	Other stomach/intestinal conditions

Y	N	INFECTIOUS DISEASES
☐	☐	Does your child/adolescent have any infectious diseases?
☐	☐	Tuberculosis (TB)
☐	☐	HIV positive or AIDS
☐	☐	Fever blisters/mouth sores
☐	☐	Other infectious or immune conditions _____

Y	N	ORTHOPEDIC / MUSCULOSKELETAL
☐	☐	Does your child have any orthopedic or musculoskeletal conditions?
☐	☐	Bone or joint conditions

Y	N	DEVELOPMENTAL
☐	☐	Does your child/adolescent have any developmental conditions?
☐	☐	Genetic disorder
☐	☐	Cerebral palsy
☐	☐	Cleft lip or palate
☐	☐	Intellectual disability
☐	☐	Speech conditions
☐	☐	Developmental delay
☐	☐	Autism spectrum disorder
☐	☐	ADHD
☐	☐	Prematurity or preterm birth
☐	☐	Other developmental or acquired disability

When was the onset of puberty for your child/adolescent?

(For girls) First period: Month_____Year _____

Y	N	SOCIAL
☐	☐	Does your child/adolescent have any social conditions?
☐	☐	Recreational drug or alcohol use
☐	☐	Smoking or tobacco use

Y	N	OTHER
☐	☐	Does your child/adolescent have any other medical conditions?
☐	☐	Skin conditions
☐	☐	Cancer, cancer treatment **If yes**, what type/location_____
☐	☐	Pregnant or nursing If pregnant, expected delivery date _____
☐	☐	Recent rapid growth
☐	☐	Emotional/behavioral/psychiatric conditions
☐	☐	Does your child/adolescent have any other conditions not listed above?
☐	☐	Does your child/adolescent have any conditions requiring accommodation?

MEDICATIONS AND ALLERGIES

List any current or recent medications your child takes:

Allergies or reactions to any medicines?

Medication name: _____Reaction: _____

Medication name: _____Reaction: _____

Medication name: _____Reaction: _____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my treatment and my treatment results.

Your signature: _____

Consent For Insurance Release/Authorization/Assignment and Financial Responsibility

Patient Name:_____ **Date of Birth:**_____

Please Read Each Paragraph and Initial

Insurance Verification/Release/Authorization/Assignment

_____ I certify that the information pertaining to my active dental and/or medical insurance coverage is correct.

_____ I authorize the release of any dental/medical records or other information, including the diagnosis and treatment rendered to me, as requested by my dental and/or medical insurance carrier. I am aware this may include information regarding HIV or AIDS, alcohol or drug abuse and psychiatric treatment.

_____ I request and assign benefit payment(s) from my insurance carrier(s) directly to the Dental Faculty Practice and to the practitioner who rendered my service.

Financial Responsibility

_____ I understand that payment is expected in full prior to the services being rendered for patients who do not have dental or medical insurance (if applicable) coverage.

_____ I understand that should I arrive on the day of my appointment with no means of payment, the Dental Faculty Practice reserves the right to reschedule my appointment.

_____ Missed or Broken appointments (if less than 24 hours' notice) may have a fee assessed at the provider's discretion and this fee is the patient's responsibility.

Patients who have verified dental (and/or medical, if applicable) insurance benefits

_____ I understand that the financial obligation for any services rendered/received is my responsibility and not the responsibility of the Dental Faculty Practice, my provider of service or my insurance carrier. I understand that the Dental Faculty Practice will make reasonable effort on my behalf to obtain all applicable benefits from my insurance carrier(s), but there is no promise or guarantee of payment/coverage. Any balance due after insurance processing and/or insurance payment received is my responsibility. *****Note** Account balance is due 60 days from the date of service, whether payment has been received from your insurance carrier or not.***

_____ I understand that my Dental Faculty Practice provider may not be an "in-network" provider with my medical and/or dental insurance carrier and services/procedures may be subject to out-of-network deductibles, allowables and co-payments.

_____ Co-payment, deductible and deposit (in some cases) is payable prior to the services being rendered. A predetermination of dental benefits may be submitted (time permitting) prior to initiation of treatment in order to obtain the estimated patient out-of-pocket expense. If you would like a predetermination of dental benefits, please contact the insurance/financial department.

_____ Account balances must remain in good standing to avoid collection proceedings. Payment contracts/ arrangements must follow agreed upon guidelines. Past due account balances (90+ days) will be forwarded to our collection agency.

Payment Options

- Cash, check, MasterCard, Visa, Discover, American Express or debit cards are acceptable.
- H.S.A. (if applicable) and Flexible Spending benefit cards or checks are acceptable.
- Care Credit - For those patients who prefer to extend payments beyond the conclusion of treatment. We are pleased to offer Care Credit; the American Dental Association's approved commercial line of credit, specifically designed for the payment of dental care. To learn more about Care Credit, feel free to speak to the insurance/ financial department.

*****NOTE**** *A NSF fee of $34 will be charged for returned checks*

****PLEASE NOTE**** - **Divorced Parents: *The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.***

_____ **MEDICAID PATIENTS** I understand I must submit my current Medicaid identification card on the day service is rendered. I also understand after Medicaid has processed the claim there may be a portion of the balance which will be my responsibility. I agree to pay this balance within 30 days.

_____ **MEDICARE PATIENTS** I understand that Medicare rarely covers dental procedures and I am responsible for the full fee associated with such services. I understand that after Medicare processes my claim, any balance due is my responsibility. I agree to pay this balance within 30 days.

_____ **BWC/TRAUMA/ACCIDENT PATIENTS** I understand that it is my responsibility to notify the insurance department that I am being treated as a result of an injury **prior to** any services being performed. A treatment coordinator from the insurance/financial department will be assigned to my case to work with me in regard to insurance/financial matters.

FINANCIAL RESPONSIBILITY / *WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT?*

___ **PATIENT IS RESPONSIBLE PARTY**

RESPONSIBLE PARTY INFORMATION (Complete if patient is not Responsible Party)

NAME_____RELATIONSHIP ___Spouse ___Parent ___Other

DATE OF BIRTH_____SOCIAL SECURITY #_____

HOME PHONE_____CELL PHONE_____

HOME ADDRESS
STREET_____

CITY_____STATE_____ZIP_____

EMPLOYER_____PHONE_____

ALTERNATE CONTACT (CLOSEST RELATIVE WHO DOES NOT LIVE WITH YOU)

NAME_____RELATIONSHIP_____PHONE_____

By signing below I verify that I have read, understand and accept the guidelines and terms stated within the Dental Faculty Practice Initial Consent for Treatment, Insurance Release/Authorization/Assignment and Financial Responsibility form and that I am the financially responsible party for this patient's account.

Print Name of Responsible Party_____

Signature _____**Date**_____

Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means. This would include mailing correspondence to the individual's office instead of the individual's home, emailing correspondence (via secure email server) and/or the use of text messaging systems.

I wish to be contacted in the following manner (*check all that apply*):

Home Phone (_____)_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with callback number only

Cell Phone (_____)_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with callback number only
- ☐ O.K. to text appointment information
- ☐ O.K. to text account/financial information

Work Phone (_____)_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with callback number only

Written Communication - U.S. Mail/Fax

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to number indicated below

Fax # (_____)_____

Written Communication - E-mail (via secure email server)

- ☐ O.K. to email appointment information
- ☐ O.K. to email account/financial information

Email Address:

_____

I hereby grant permission for Dental Faculty Practice providers and/or representatives to share clinical and financial information with or answer questions from (*check all that apply and print name or names*):

- ☐ Spouse _____
- ☐ Parent _____
- ☐ Child _____
- ☐ Other (name and specify relationship):_____
- ☐ Direct patient contact only

Patient or Guardian Signature_____

Print Name of Patient or Guardian_____

Date Signed_____