Patient Information

Name: _____ **DOB:** _____

Parent or Guardian:_____

Phone Number:_____ **Are you OK receiving texts messages? Yes/No**

Email:_____

Address:_____ **City:**_____**State:**_____**Zip:**_____

Emergency Contact:_____ **Phone Number:**_____

Relationship:_____

Who can we thank for referring you?_____

Insurance Information

Policy Holder's Name:_____
Policy Holder's DOB:_____
Policy Holder's SSN:_____
Policy Holder's Address:
_____
Policy Holder's Phone Number:
_____
Policy Holder's Employer (If benefits are through an employer):
_____

Dental Insurance Company:
_____
ID Number:
_____
Group Number:
_____
Phone Number on the back of your insurance card:_____
Address on the back of your insurance card:
_____

Secondary Insurance Information (if applicable)

Policy Holder's Name:_____
Policy Holder's DOB:_____
Policy Holder's SSN:_____
Policy Holder's Address:
_____
Policy Holder's Phone Number:
_____
Policy Holder's Employer (If benefits are through an employer):
_____

Dental Insurance Company:
_____
ID Number:
_____
Group Number:
_____
Phone Number on the back of your insurance card:_____
Address on the back of your insurance card:
_____

Health History

COLUMBIA HEALTHY SMILES

Name: _____ Date: _____

Are you currently under the care of a physician? **Yes/No**

Physician:_____

Office Phone:_____

Date of Last exam:_____

Have you ever been hospitalized for any serious illness within the last 5 years? **Yes/No**
If yes, please explain.

_____

_____

Are you taking any medication(s) including non-prescription medication? **Yes/No**
If yes, what are you taking?

_____

_____

Have you ever taken Fen-Phen/Redux? **Yes/No**
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? **Yes/No**
Have you ever taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? **Yes/No**
Do you use tobacco? **Yes/No**
Do you use controlled substances? **Yes/No**
Are you wearing contact lenses? **Yes/No**

Do you have a persistent cough or throat clearing not associated with any known illness lasting more than 3 weeks? **Yes/No**

Women only:

Are you pregnant or think you may be pregnant? **Yes/No**
Are you nursing? **Yes/No**
Are you taking oral contraceptives? **Yes/No**

Are you allergic to or have any reactions to the following?

- ☐ Local Anesthetics
- ☐ Penicillin or any other Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Any Metals (nickel, etc.)
- ☐ Latex Rubber
- ☐ Other

(Please List)_____

Please continue on back

Do you have or have had any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Alzheimer's/Dementia	☐	☐	Stomach Troubles/Ulcers	☐	☐
Heart Attack	☐	☐	Autism	☐	☐	Chest Pains	☐	☐
Rheumatic Fever	☐	☐	Psychiatric Conditions	☐	☐	Easily Winded	☐	☐
Swollen Ankles	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐
Fainting/Seizures	☐	☐	Cardiac Pacemaker	☐	☐	Hay Fever/Allergies	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Angina	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions	☐	☐	Frequently Tired	☐	☐	Glaucoma	☐	☐
Leukemia	☐	☐	Anemia	☐	☐	Recent Weight Loss	☐	☐
Diabetes	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐
Kidney Diseases	☐	☐	Cancer	☐	☐	Heart Trouble	☐	☐
AIDS or HIV Infection	☐	☐	Arthritis	☐	☐	Respiratory Problems	☐	☐
Thyroid Problem	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse	☐	☐
Anxiety	☐	☐	Hepatitis/Jaundice	☐	☐	Other _____	☐	☐
Depression	☐	☐	Sexually Transmitted Disease	☐	☐			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing false information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payors and/or health practitioners.

_____

Signature of Patient (or parent/guardian if minor) **Date**

COLUMBIA HEALTHY SMILES

Philip A. Batson, D.D.S. & Elizabeth Abe, D.D.S.
2516 Forum Blvd. Ste. 200
Columbia, MO 65203
P: 573-875-7071 F: 573-875-7072

Records Release Form

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

I, _____, hereby authorize the doctors and staff of

Patient's Name (Parent/Legal Guardian)

Columbia Healthy Smiles to release records concerning my dental health. I understand the specific type of information disclosed may include a detailed report of examinations, treatment provided, x-rays and other records that pertain to my dental information.

Please select one:

___1. Records given directly to me (or parent/guardian, if patient is a minor)

___2. Records to be sent to another dental office (complete below)

Name of Dental Practice/Dentist: _____

Email Address: _____

This authorization is effective until I cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed: _____ Date: _____

Patient (Parent/Legal Guardian if minor)