11 Medical Drive
Chillicothe, OH 45601
740-775-8050 ph 740.775.8053 fax

Magnolia DENTAL

WWW.MYMAGNOLIASMILE.COM

Welcome To Our Practice! Serving You Exceptional Care with Southern Hospitality

Date: _____

Patient Information

Patient Name _____ (Last Name) _____ (First Name) SS# _____ Birthdate ___/___/___

Gender ☐ M ☐ F Age _____ Nickname _____

Home Phone _____ Cell _____ Email Address _____

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How did you hear about our practice? _____ Friend's Name (If Applicable) _____

Emergency Contact _____ Phone Number _____

Responsible Party

Name of person responsible for this account (if someone other than yourself) _____ (Last Name) _____ (First Name)

Relationship _____ DL# _____ SS# _____ Birthdate ___/___/___

Home Phone _____ Cell _____ Email Address _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Employer _____ Work Phone _____

Is this patient currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Primary

Do you have insurance to assist you with payment? ☐ Yes ☐ No

Name of Insured _____

Relationship _____ SS# _____

Birthdate ___/___/___ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Do you have a deductible? ☐ Yes ☐ No ☐ I'm not sure

Do you know your maximum annual benefit? ☐ Yes Amount $ _____ ☐ No

Have you used this insurance at a dental practice before? ☐ Yes ☐ No

Secondary

Do you have insurance to assist you with payment? ☐ Yes ☐ No

Name of Insured _____

Relationship _____ SS# _____

Birthdate ___/___/___ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____

Do you have a deductible? ☐ Yes ☐ No ☐ I'm not sure

Do you know your maximum annual benefit? ☐ Yes Amount $ _____ ☐ No

Have you used this insurance at a dental practice before? ☐ Yes ☐ No

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Medical History

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 physician's care now? ☐ Yes ☐ No If Yes, please explain _____
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 explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If Yes, please explain _____
Do you take or have you taken, Phen-Fen or Redux? _____
Are you on a special diet? _____
Do you use tobacco? _____
Do you use controlled substances? _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs
☐ Other _____

Women Only: Are you: Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking Oral Contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

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

AIDS/HIV Positive	☐ Yes ☐ No	Cortizone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Recent Weights Loss	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hives or Rashes	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hypoglycamia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Vereal Disease	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

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

Comments & Signature

_____
_____
_____
_____

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 Magnolia Dental of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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Practice Financial Policy

We are committed to providing you and your family with the best possible care and are pleased to discuss our professional fees with you at any time, and your insurance coverage, with you at any time. Your clear understanding of our financial and insurance policies is important to our relationship. Please ask us, at any time, if you have any questions about this policy.

- All patients must complete and sign the Patient Registration and History form before seeing the Doctor.
- We accept most insurance plans and will gladly process your claim. Please notify us of any changes in your insurance plan and bring your current insurance card to each visit. Insurance policies generally cover only a portion of the total treatment cost. *Unless other arrangements have been made, we ask that you pay your portion of the bill at the time of treatment. It is your responsibility to pay any balance not paid by your insurance company.*
- For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover, and American Express. Financing is also available through Care Credit.
- Twenty-four hour notice is required when re-scheduling or canceling an appointment. A cancellation fee of $25.00 may be assessed for broken appointments with less than twenty-four hour notice.
- Treatment plans may change, and you will be responsible for the treatment actually completed.
- For your convenience, this office may release your information to your insurance company, and receive payment directly from them. Every effort will be made to help you with your insurance, however, the insurance company, not our office, determines the dental benefits that you receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- If sent to collections, you understand that it is your full financial responsibility to pay all court costs and all collection fees and/or attorneys fees.

I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors. I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I am responsible for payment regardless of insurance company's arbitrary determination of reasonable and customary rates. I understand that payment is expected when services are rendered unless other arrangements are made in advance. I have been given a copy of the HIPAA or have viewed the CASEY presentation of the HIPAA information.

Patient Name _____ Birthdate ___/___/____

_____ Date: _____

Signature of Parent or Guardian

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Patient Habits

Although you may not be aware, many common habits can affect your oral health. Please take a moment to review the chart below and indicate which box reflects your habits. Your honesty is important and, as always, your responses will remain confidential.

Habit	I do this now	I used to do this	How long?	How much?	I don't do this
Grind your teeth					
Bite or chew your cheek					
Bulimia Anorexia					
Smoke cigar or Cigarettes					
Smoke pipe					
Chew tobacco					
Bite nails					
Suck thumb or finger					
Use a toothpick or stimulator					
Chew gum					
Eat candy					
Soft drinks					
Crunch hard foods (like popcorn)					
Chew ice					
Suck on mints or candies					
Use recreational drugs					