Healthy Smile Dentistry

2645 Bethel Road
Columbus, Ohio 43220
(614) 457-3300

Patient **Insurance** Information

Patient ID #

PERSONAL INFORMATION Date: _____

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work):_____

(Cell) _____ E-mail: _____

Birth date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____ Phone: _____

Insurance Co. Address: _____

Subscriber: _____Birth Date: _____Relationship: _____ Member ID #: _____

Employer: _____ Group #: _____

Secondary Insurance Co: _____ Phone: _____

Insurance Co. Address: _____

Subscriber: _____Birth Date:_____ Relationship: _____ Member ID #: _____

Employer: _____ Group #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

Continued on Next page

Patient **Dental** Information

Patient ID #

Name of Previous Dentist: _____ Date of Last Exam: _____

Previous Dentist's Location:_____ Date Of Last Cleaning: _____

YES	NO	
❑	❑	1. Do your gums bleed while brushing or flossing?
❑	❑	2. Are your teeth sensitive to hot or cold liquids/foods?
❑	❑	3. Are your teeth sensitive to sweet or sour liquids/foods?
❑	❑	4. Do you feel pain in any of your teeth?
❑	❑	5. Do you have sores or lumps in you mouth?
❑	❑	6. Have you had any head, neck or jaw injuries?
		7. Have you ever experienced any of the following problems in your jaw?
❑	❑	a. clicking
❑	❑	b. Pain (joint, ear side of face)?
❑	❑	c. Difficulty in opening or closing you jaw?
❑	❑	d. Difficulty in chewing?
❑	❑	8. Do you have frequent headaches?
❑	❑	9. Do you clench or grind your teeth?
❑	❑	10. Do you bite your lips or cheeks frequently?
❑	❑	11. Have you ever had any difficult teeth extractions in the past?
❑	❑	12. Have you ever had prolonged bleeding following tooth extraction?
❑	❑	13. Have you had any orthodontic treatment?
❑	❑	14. Do you wear dentures or partials? If yes, Date of placement: _____.
❑	❑	15. Have you ever received oral hygiene instruction regarding the care of your teeth and gums?
❑	❑	16. Do you like your smile?

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 incorrect information can be dangerous to my health. I authorize Healthy Smile Dentistry, LLC and the Dentist: Dr. Sahar Hamzeh, to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child, during the period of such dental care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

Patient Signature_____ Date: _____

Doctor's Signature: _____ Date: _____

Continued on Next page

Financial Policy Acknowledgement

I have read or someone has read the form to me, and I received a copy of the Financial Policy. I agree to follow the policy.

_____ _____

Printed Patient or Responsible Party Name Date

_____

Signature for Patient or Responsible Party

Cancellation Policy Acknowledgement

I have read or someone has read the form to me, and I received a copy of the cancellation Policy. I agree to follow the policy.

_____ _____

Printed Patient or Responsible Party Name Date

_____

Signature for Patient or Responsible Party

Receipt of Privacy Practices Notice Acknowledgement

I have read or someone has read the form to me, and I received a copy of the Notice of Privacy Practices for Healthy Smile Dentistry, Ltd.

_____ _____

Printed Patient or Responsible Party Name Date

_____

Signature for Patient or Responsible Party