PATIENT WELCOME FORM

COLUMBIA IMPLANT CENTER

Today's Date: _____

PATIENT INFORMATION

Patient Legal Name: First Middle and Last		Sex	Birth Date	Social Security #
Preferred Name		Preferred Title	Marital Status	Email
Home Address		State	Zip Code	Home Phone
City	Cell Phone #	Home Phone #		Work Phone #
Emergency Contact Name / Relationship	Emergency Contact Phone#	Referral Source		
Dental Insurance Co Name	Policy ID	Subscribers Name		Dental INS Phone #
Subscriber's Employer				Subscriber SSN

This above information is required for accurate billing purposes

Reference to Columbia Implant Center includes or may include its employees, agents, assigns and representatives.

Communication Practice

□I agree that we may contact you from time to time by mail, □Voice message □ email or □ text to the phone numbers provided above to remind you of appointments, outstanding statements due, special events, offers , or coupons. Text STOP to unsubscribe from messages.

□ I agree that the dental practice may communicate with me electronically at the □ email address □mobile/ cell number I provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails and text messages. I am responsible for providing the dental practice any updates to my email address and my cell phone number.

Do you prefer a Reminder before your Appointment?
□ Stop reminder after confirmation.

RELEASE OF INFORMATION

You may discuss my health care with □ Spouse / partner □ Children □ Parents □ Other _____ (Names)

Assignment & Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits and collection of fees and charges by the provider or its assignee and or agent and to defend any claim by me or on my behalf. I Authorize the use of this signature on all my insurance submissions whether manual or electronic. I hereby authorize any available insurance benefits to be paid directly to the provider it it's assignee.

Billing and Insurance

As a courtesy to our patients, Columbia Implant Center submits bills to your insurance company and will do everything possible to advance your claim. However, it may become necessary for you to contact your insurance company or supply additional information to them for claims processing requirements or to expedite payment. You should remember that your policy is a contract between you and your insurance company, and you have the final responsibility for payment of your dental bill. The estimate shows our estimate for procedures or other services at Columbia Implant Center. The actual charge may vary depending on your dental condition and other factors, including regular changes to our rates or network status of our providers after the date these charges were estimated. The charges you see are the standard charges – for example, they do not take actual third-party insurer actual coverage into account – for each procedure or service. To find out how much of the total charge for services you may be expected to pay, contact your insurance company to determine your specific benefits and expected out-of-pocket expenses.

Please note that: (1) Out-of-network providers may balance bill an individual member for the difference between what the provider billed and the member's cost share amount (i.e., copayment, deductible, or coinsurance) if and when balance billing is permitted under state or federal law; (2) the actual charge may be different from an estimate; and (3) the availability of a cost-share estimate is not a guarantee of coverage

Estimates

The estimate shows our estimate for procedures or other services at Columbia Implant Center. The actual charge may vary depending on your dental condition and other factors, including regular changes to our rates or network status of our providers after the date these charges were estimated. The charges you see are the standard charges – for example, they do not take actual third-party insurer actual coverage into account – for each procedure or service. To find out how much of the total charge for services you may be expected to pay, contact your insurance company to determine your specific benefits and expected out-of-pocket expenses.

Please note that: (1) Out-of-network providers may balance bill an individual member for the difference between what the provider billed and the member's cost share amount (i.e., copayment, deductible, or coinsurance) if and when balance billing is permitted under state or federal law; (2) the actual charge may be different from an estimate; and (3) the availability of a cost-share estimate is not a guarantee of coverage.

□ I confirm that I have read and understood the terms & conditions.

□ I am NOT a Medicaid beneficiary □ I AM a Medicaid beneficiary

Notice of Privacy Act Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information.

The complete description is available at Columbia Implant Center and I may review or receive a personal copy by asking the front desk.

□ I authorize the making of videotapes, photographs ad x-rays oof my dental care treatment (collectively "My Images"), and Columbia Implant Center's use of My images in scientific papers, demonstrations and/or presentations without any compensation to me. I understand that I may withdraw my consent at any time in writing to Columbia Implant Center.

□ I hereby authorize the making of videotapes, photographs and x-rays of my dental care ("My Images"), and Columbia Implant Center's use of My Images in social media without compensation. I understand that I may withdraw my consent, in writing to Columbia Implant Center at any time.

Patient Name (printed): _____ Relationship to the patient: _____
Signature of Patient or Parent (Guardian): _____ Date: _____/_____/_____

HEALTH HISTORY

Today's Date: _____ Patient Name: _____ DOB: _____

EMAIL: _____ CELL PHONE: _____

Physician's Name: _____ CITY: _____

Please Answer ALL QUESTIONS by CIRCLING yes (Y) or no (N) or specifying

1 Date of last physical exam: _____

2 Are you currently under a physician's care for a particular problem? Y N

3 Have you had any serious illness, operations or hospitalizations? If so, please describe:
_____

4 Do you have or have you ever had (Please Circle)

A	Rheumatic Fever or Rheumatic Heart Disease?	Y	N
B	Congenital Heart Disease (Birth Defect)?	Y	N
C	Cardiovascular Disease - *Please specify*- Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Heart Failure, Stroke, Palpitations, Heart Surgery, Pacemaker	Y	
D	Lung Disease (*Specify*) – Asthma, Emphysema, Chronic cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing	Y	N
E	Cancer? Type: _____	Y	N
F	Seizures, Convulsions, Epilepsy, Fainting?	Y	N
G	Psychiatric Treatment, Nervous disorders or Breakdown? (*specify*)	Y	N
H	Bleeding disorder, Anemia, Bleeding Tendency, Blood Transfusion (*specify*)	Y	N
I	Liver Disease, Hepatitis, Cirrhosis?	Y	N
J	Sleep Apnea (CPAP)	Y	N
K	Kidney Disease/Dialysis	Y	N
L	HIV	Y	N
M	Diabetes?	Y	N
N	Thyroid Disease?	Y	N
O	Arthritis/Osteoporosis/Osteopenia	Y	N
P	Stomach Ulcers/ Colitis /GERD	Y	N
Q	Glaucoma or other eye disease _____	Y	N
R	Frequent or recurring mouth sores?	Y	N
S	Joint Replacement/Artificial Heart Valve	Y	N
T	Radiation Treatment or Chemotherapy	Y	N
U	Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?	Y	N
V	Sinus or Nasal problems?	Y	N

5 Do you have any other disease, condition or problem not listed the doctor should know about? Y N

_____

_____

6 Are you using or taking any of the following?

a.	Thyroid Medications?	Y	N
b	Antibiotics or Sulfa drugs	Y	N
c	Anticoagulants (blood thinners)	Y	N
d	High Blood Pressure Medications?	Y	N
e	Tranquilizers (Valium, etc.)?	Y	N
f	Insulin, Diabinese or Similar Drug?	Y	N
g	Digitalis, Inderal, Nitroglycerin, Calcium channel blockers, Procardia, or other Heart medicine	Y	N
h	Aspirin or Ibuprofen (Motrin, Naprosyn etc.) Daily Dose? _____	Y	N
i	Marijuana or other "street" drugs?	Y	N
j	Antihistamines or Decongestants?	Y	N
k	Bisphosphonates, Fosamax, Boniva, Reclast	Y	N
l	Please List Your Current Medications: _____ _____ _____		

7 Are you allergic or had a bad reaction to:

a	Latex or Rubber products	Y	N
b	Local Anesthetic (Novocain, etc..)	Y	N
c	Penicillin or other antibiotics?	Y	N
d	Barbiturates, sedatives, etc.?	Y	N
e	Aspirin or Ibuprofen?	Y	N
f	Codeine or other pain killers?	Y	N
g	Other allergies or reactions Please List: _____	Y	N

8 Do you smoke or chew tobacco? Y N

9 Do you drink alcohol? Y N

10 Do you use recreational drugs? Y N

11 **FOR WOMEN ONLY**

a	Are you taking oral contraceptives?	Y	N
B	Are you pregnant or nursing?	Y	N

PHARMACY: _____ Phone Number: _____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor and confirm that it adequately states the past and present conditions.

Guardian/Patient Signature: _____ Doctor's Initials: _____