PATIENT WELCOME FORM

COLUMBIA IMPLANT CENTER

Today's Date: _____

PATIENT INFORMATION

Patient Name		Sex	Birth Date	Social Security #
Home Address				
City		State	Zip Code	Home Phone
Cell Phone	Email Address	Emergency Contact		Phone Number
Insurance Co Name	Policy ID	Subscribers Name		INS Phone #
Subscriber's Employer				Subscriber SSN

Communication Practice

We may contact you from time to time by mail, email or text to your mobile phone to remind you of appointments, outstanding statements due, special events, offers or coupons.

Our mobile test messages are intended for subscribers over the age of 13 and are delivered via USA long code 8447340111. You may receive up to 5 messages per month for these purposes. Message and data rates may apply.

This service is available to persons with text-capable phone subscribing to carries including AT&T, Verizon Wireless, T-mobile®, Sprint, Virgin Mobile USA, Cincinnati Bell, Centennial Wireless, Unicel, U.S. Cellular®, and Boost. For help, test HELP to 8447340111, email (columbiaimplantcenter@colubiadental.com), or call (860-730-6020). You may stop your mobile subscriptions at any time by text messaging STOP to long code 8447340111..

I understand:_____ Signature: _____

Notice of Privacy Act Acknowledgement

I understand that, under the Health Insurances Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider who may be involved in my treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

The complete description is in the binder. Please feel free to review and/or obtain a personal copy by asking the front desk).

I understand that I may request that you restrict how my private information is to be used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name (printed): _____ Relationship to the patient: _____

Signature of Patient or Parent (Guardian): _____ Date: _____/_____/_____

HEALTH HISTORY

EMAIL: _____ CELL PHONE: _____

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

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: _____