Blue Ash Family Dentistry :) Dr. Bartnik

Patient Full Name: _____ Today's Date_____

Address_____ City_____ State_____ Zip_____ Gender: **F M**

SS# _____ Date of Birth_____ Age_____ Single Married Widow Minor

Phone **CELL** : _____wk:_____home: _____

Email _____ Occupation _____

Whom may we thank for referring you to us?_____

INSURANCE INFORMATION

Primary Carrier:

Name of Insured _____ SS#_____

Relation to patient _____

DOB _____ Employer_____

Carrier_____ Group Policy #_____

Second Carrier or Spouse Information:

Name of Insured/ Spouse _____ SS#_____

Relation to patient _____

DOB _____ Employer_____

Carrier_____ Group Policy #_____

RESPONSIBLE PARTY (If patient is a minor) :

Name _____Relation_____

Address_____

Phone numbers Home_____ Work_____Cell_____

Reason for visit today: _____

Is there anything you would like to speak with the doctor about in private? No Yes

Do you have a family member that sees us? _____

Physician's Name _____ Last physical examination_____

Prior Dentist _____ Last dental exam _____Last dental x-rays _____

Women

Are you pregnant? No Yes Due Date:_____

Are you breastfeeding? No Yes

Please circle any allergies:

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Metals
Other_____

Please list medications you are currently taking:

_____

_____

Please indicate with a circle if you have had or have taken any of the following:

Chest Pain
Heart Problems
Heart Surgery
*Congenital Heart Problems
Liver Disease/Jaundice
High Blood Pressure
Eating Disorder
*Any type of Implant
*Any type of Transplant
*Artificial Joint
Sinus Trouble
Sickle Cell Disease
Thyroid Disease
Anemia
Blood Transfusion
Psychiatric Treatment
Shortness of Breath
Emphysema
Cold Sores
Oral Herpes
Emphysema
Fainting or Dizzy Spells
Arthritis
Fosomax
Persistent Cough
Asthma
Use of Tobacco Products
Hepatitis A B C Other
Drug Addiction
Alcoholism
Ulcers
Hives or Skin Rash
Kidney Trouble
Hemophilia
Angina Pectoris
Glaucoma
*Steroid Treatment
Epilepsy or Seizures
Bruise Easily
Tuberculosis (TB)
HIV+
Bisphosphonate Treatment
Dentures or Partials
Stroke
Radiation/Chemo Therapy
Diabetes

Please indicate with a circle if you are currently experiencing:

Swelling in your mouth
Gum Problems
Bad taste in your mouth
Grinding teeth
Loose tooth or teeth
Dry mouth
Bad breath
Jaw Pain

Please indicate with a circle any sensitivity to:

Hot Cold Sweet Biting/Pressure

EMERGENCY contact: Name:_____ Relationship:_____ Phone # _____

Blue Ash Family Dentistry's Policy

I, _____ (print name) certify I have read and understand the above information. The questions have been accurately answered. I understand that providing incorrect 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 me or my child during the period of such dental care to third party payors and/or healthcare practitioners.

* I agree to always bring my current dental insurance card at the time of service. I acknowledge that it is my responsibility to understand how my insurance works. I authorize and request my insurance company to pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for rendered services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.
* I also understand I need to give Blue Ash Family Dentistry a 24 hour notice of any cancelations or changes to appointments, or I will be charged a **$25 fee**.

I acknowledge that I have received and read a copy of the Notice of Privacy Practices Sheet.

Patient/Parent Signature _____Date_____