



Welcome

Quality Care for Cosmetic and Sedation Dentistry

Firas Salhi, DDS • **Terrylynn Tennant, DMD, AADSM**

A very warm welcome to you! The entire team would like to thank you for selecting our office to care for your dental needs. Our goals are to provide each patient with the highest quality dental care in a gentle, efficient, and pleasant manner, and to strongly encourage prevention of future dental problems.

- We will put your needs and wishes first and advise you on the best long-term preventive plan for healthy teeth.
- We use only the best material and labs. All instruments go through a steam auto-clave for sterilization. All services are rendered with the latest techniques available.
- We base our measure of success on the quality of the relationship we have with each patient, not just on the quality of the dental service we provide.
- We take special interest in helping the fearful or sensitive patient, who may have had difficulty before, and may be avoiding dental treatment because he or she has been hurt elsewhere.

Should you have any questions, please do not hesitate to confide in us regarding any Worries you have about your oral health. We'll always take time to answer your questions and give you every reason to smile. That's why we're here.

We have someone on call 24 hours a day, so if you need us – we're here for you. Enclosed are the new patient forms, please fill them out and bring them with you to your appointment.

We look forward to meeting and getting to know you.

The Staff of Columbia Square Dental



Welcome

PATIENT INFORMATION Today's Date: _____

Name: _____

Birthdate: ____/____/____ Soc. Sec. #: _____ - _____ - _____

Address: _____

City/State: _____ Zip: _____

Phone: Hm:() _____ - _____ Wk :() _____ - _____

Cell:() _____ - _____

Employer: _____

RESPONSIBLE PARTY (IF, Other than Patient)

Name: _____

Birthdate: ____/____/____ Soc. Sec. #: _____ - _____ - _____

Address: _____

City/State: _____ Zip: _____

Phone: Hm:() _____ - _____ Wk :() _____ - _____

Cell:() _____ - _____

Employer: _____

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

Please circle your method of payment today;

CASH • CHECK • CREDIT CARD • CARE CREDIT

Preferred Method of Receiving Appointment Confirmations

PHONE TEXT EMAIL: _____

Preferred Pharmacy: _____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER: Self Other (Fill out below)

Name: _____

Birthdate: _____ Relation to Patient: _____ Ins. Company: _____

Group #: _____

Phone #: _____

Address: _____

City/State: _____ Zip: _____

Employer: _____

Soc. Sec. # / ID#: _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER: Self Other (Fill out below)

Name: _____

Birthdate: _____ Relation to Patient: _____

Ins. Company: _____

Group #: _____ Phone #: _____

Address: _____

City/State: _____ Zip: _____

Employer: _____

Soc. Sec. # / ID#: _____

Spouse's Name: _____ Employer: _____ Wk #:() _____ - _____

Emergency Contact: _____ Phone#:() _____ - _____

Is another member of your family or relative a patient at our office:

Name: _____ Relationship: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PATIENT CONSENT FOR TREATMENT

- 1) I authorize the doctor / staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
- 2) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- 3) I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

MEDICARE

I understand that Columbia Square Dental has *opted out of Medicare*. This should have little or no effect on me since Medicare does not cover most dental services. By opting out, neither I nor Columbia Square Dental can bill Medicare for any dental services rendered.

INSURANCE

Insurance will be billed according to the billing / payment guideline of my primary insurance. I understand that as a courtesy, Columbia Square Dental will submit insurance claims on my behalf; however, they do not guarantee any payment of benefits.

If my insurance coverage does not cover the estimated amount, I will be responsible for payment in full. Additionally, if I fail to provide accurate insurance information to the business office within 15 days of the date of service, I will be expected to pay the account in full and get reimbursed from my insurance carrier.

Deductibles, co-insurance, non-covered services (including pre-existing conditions), and services denied due to insurance eligibility is my responsibility. I authorize my insurance company(s) to pay Columbia Square Dental all Insurance benefits for dental services rendered to me or members of my family.

FINANCIAL AGREEMENT

I agree to be responsible for payment of all services rendered on my behalf or my dependents. **I understand that payment is due at the time of service unless other arrangements have been made.** In the event that payments are not received by agreed upon dates, I understand that a 1 ½ % late charge (18% APR) may be added to my account.

Additional Charges:

- I know that ***I must call to cancel an appointment at least 24 hours*** (1 day) before the time of the appointment. If I do not cancel and do not show up a \$50 charge will be assessed for time reserved and future appointments will need to be prepaid.
- I understand that delinquent accounts will be assigned to a credit reporting collection agency and I will be charged a ***\$100*** collection fee.
- I understand that a \$25 fee will be charged to transfer records electronically.

HIPAA

Release of Information:

- I give consent to the doctor's or designated staff's use at Columbia Square Dental to disclose any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, referral to other healthcare professionals and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
- I would like a copy of this office's "Notice of Privacy Practices"? Yes No

(If box is left un-checked, we will assume you do not want a copy)

I acknowledge that I read English and have read and understood the contents of this form. I agree to adhere to the Above policies of Columbia Square Dental

Print Patient Name

Signature of Patient, Parent or Guardian

Date

MEDICAL HISTORY

PATIENTS HAVE THE RESPONSIBILITY to provide accurate/complete information about current and past illnesses, medications including herbal supplements, and other matters pertaining to their health and medical history. Success of treatment depends on your disclosure. If treatment fails due to your lack of disclosure of a medical condition or medication that you are taking; you may incur additional expenses for alternative additional treatment.

If answering yes, to any of the following questions, please explain in space provided

Are you undergoing Medical treatment at this time?	<input type="radio"/> Yes <input type="radio"/> No _____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No _____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No _____
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No _____
Do you take or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No _____
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No _____
Do you smoke or use tobacco?	<input type="radio"/> Yes <input type="radio"/> No _____
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No _____
Are you being treated for Osteoporosis?	<input type="radio"/> Yes <input type="radio"/> No _____
Are you taking Fosomax, Boniva or Actinal ?	<input type="radio"/> Yes <input type="radio"/> No _____

WOMEN: Are you Pregnant / trying to get pregnant? Yes/ No Taking Oral Contraceptives? Yes/ No Nursing? Yes/ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin Penicillin Codeine Acrylic Metal Latex
 Local Anesthetics Other - If yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Aids/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Meds	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes Type:	<input type="radio"/> Yes <input type="radio"/> No I or II	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B/ C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy/ Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint What Type: Date Placed:	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting/ Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/ Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches/Migraines	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors / Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble / Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____
 Do you snore or stop breathing during Sleep? Yes No If yes, please explain: _____

Comments: _____

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 the dental office of any changes in medical status.

Printed Patient Name _____

Signature of Patient, Parent or Guardian _____

Date _____

DENTAL HEALTH HISTORY

- Are you apprehensive about dental treatment? Yes No
- Have you had problems with previous dental treatment? Yes No
- Do you gag easily? Yes No
- Do you wear dentures? Yes No
- Does food catch between your teeth? Yes No
- Do you have difficulty chewing your food? Yes No
- Do you chew on only one side of your mouth? Yes No
- Do your gums:
- Bleed easily? Yes No
 - Bleed when you floss? Yes No
 - Feel swollen or tender? Yes No
- Have you ever noticed slow-healing sores in or around your mouth? Yes No
- Are your teeth sensitive? Yes No
- Do you feel twinges of pain when your teeth come in contact with:
- Hot foods or liquids? Yes No
 - Cold foods or liquids? Yes No
 - Sour foods? Yes No
 - Sweets? Yes No
- Do you take fluoride supplements? Yes No
- Does your jaw:
- Make noise so that it bothers you / others? Yes No
 - Clench or grind frequently? Yes No
 - Ever feel tired? Yes No
 - Hurt when you chew or open wide to take a bite? Yes No
- Do you have ear-aches or pain in the front of your ears? Yes No
- Do you have jaw symptoms or headaches upon awakening in the morning? Yes No
- Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities? Yes No
- Do you find jaw pain or discomfort extremely frustrating or depressing? Yes No
- Do you have a temporomandibular (jaw) disorder (TMD)? Yes No
- Do you have pain in the face, cheeks, jaws, joints, throat or temples? Yes No
- Are you unable to open your mouth as far as you want? Yes No
- Are you aware of an uncomfortable bite? Yes No
- Are you a habitual gum chewer or pipe smoker? Yes No
- Do you snore? Yes No
- Have you ever had a serious injury/trauma to your mouth, head or jaw? Yes No

Have you ever had:(check all that apply)

- Orthodontic Treatment? Oral Surgery Periodontal treatment? Bite adjustment?

How often do you brush? _____ Floss? _____

- Are you happy with your smile? Yes No
- If not, how would you change it? _____