THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

Ohio State Upper Arlington Dentistry
1800 Zollinger Rd., Suite 1200, Columbus, OH 43221
Phone: 614-366-3400, Fax: 614-366-8510
Email: OSUDental-UA@osu.edu

For Office Use Only: EMR #: ______________________

Patient Registration

Please complete registration in its entirety. Have your insurance card(s) and driver's license available for scanning purposes.

Mr.__________ Mrs.________ Miss_________ Ms.__________ Dr.________

Patient Name ____
Last First M.I. Maiden

Preferred Name____Birth Date_________________________

________Male ______Female Patient's Social Security Number______________________________________

Primary Language:___________________________________Do You Need an Interpreter? _____Yes ______No

Marital Status: _______Single ______Married ______Divorced Other_____________________________

Home Address: ____

____
City State Zip

Home Phone (_______)____________________________Cell Phone (_______) __________________________

Work Phone (_______)____________________________Preferred Contact # _______Home ______Cell ______Work

Email Address____May We Email You? _____Yes ______No

We utilize EasyMarkit Appointment Reminder System. Appointment reminders are sent out 48 hours prior to scheduled appointments. Please indicate your preference for reminder:

Text_________ Phone Call/Voicemail_________ Email________ I prefer not to be contacted__________

Student: _____Yes _____No Where?________________________________ _____Full Time _____Part Time

Patient's Employer______________________________ May you be contacted at work? ____________Yes __________No

Patient's Profession ____

EMERGENCY CONTACT/RELATIONSHIP____

PHONE____

Primary Care Physician: ______________________________________ Phone: ______________________
First Name, Last Name

Pharmacy Name____________________________Zip Code: ____________ Phone: ______________________

Do you have family members who are patients of our practice? _________Yes _________No

If yes, name of patient(s) ____

____

Patient Signature: ____**Date**:_______________
If patient is a minor, parent's signature

Whom may we thank for referring you to our office?

________Referred by Dentist or Physician ________Advertisement __________Internet/Website __________Family Member/Friend

________OSU Employee Benefit Fair ___________Other, please explain ______________________________________

Referral's Name (person or advertisement source)____

Adult Medical History

Patient Name:____ Date of Birth ___________________ Today's Date ____________
Last *First* *M.I.*

Y	N	General
		Height __________ft_____________in
		Weight __________lbs
		General health status (choose one): Excellent Good Fair Poor
		Are you under physician's care?
		Have you been hospitalized in the past 10 years?
		Have you had any emergency room visits in the past 10 years?
		Has your doctor limited your activity?
		Can you climb two flights of stairs without rest?

Please mark "yes" or "no" for any conditions that you have now, or have had in the past

Y	N	CARDIOVASCULAR / HEMATOLOGIC
		Do you have any heart, circulatory or blood pressure conditions?
		Heart attack (mi)
		Congestive heart failure (chf)
		Angina (chest pain)
		Heart surgery / stent / valve replacement
		Hypertension (high blood pressure) **If yes,** what is your usual blood pressure? ________________________
		Arrhythmia
		Pacemaker/ICD
		Other heart conditions:

Y	N	PULMONARY
		Do you have any lung or breathing conditions?
		Asthma
		Chronic obstructive pulmonary disease (COPD)
		Other lung or breathing conditions:

Y	N	NERVOUS SYSTEM
		Do you have any nervous system conditions?
		Seizures - **if yes,** please choose which type: Absence Grand mal Petit mal Other
		Stroke/TIA - **if yes,** please choose which type: Hemorrhagic Occlusive
		Syncop (fainting)
		Other neurological (nerve) conditions?

Y	N	GASTROINTESTINAL / LIVER / BLOOD / METABOLIC
		Do you have any gastrointestinal, liver, blood or metabolic Conditions?
		Hepatic (liver) disease
		Hepatitis
		Renal (kidney) disease
		Unusual bleeding
		Sickle cell anemia / trait
		Diabetes - **if yes**, please choose which type: **I** **II**
		Gastrointestinal (g.i.) Disease or condition
		Thyroid disease

Y	N	INFECTIOUS DISEASES
		Do you have any infectious diseases?
		Tuberculosis (tb)
		Hiv /AIDS viral load_______________cd4 count _______________
		Hepatitis B
		Other infectious or immune conditions: ____

Y	N	ORTHOPEDIC / MUSCULOSKELETAL
		Do you have any orthopedic or musculoskeletal disease?
		Bone problems or diseases (osteoporosis, others)
		Artificial joints
		Arthritis - **if yes**, please choose which type: Osteoarthritis Rheumatoid Arthritis Other
		Muscle problems or diseases ________________________________
		Jaw or jaw joint problems (TMD)

Y	N	OTHER
		Do you have any other medical conditions?
		Pregnant or nursing If pregnant, expected delivery date ______________________________
		Cancer and cancer treatment **If yes,** what type/location _____________________________________
		Emotional/psychiatric disorders ____________________________________
		Frequent sinus infections (sinusitis)
		Sleep apnea
		Do you have the symptoms below? Snore loudly Often tired, fatigued, or sleepy Observed to stop breathing or choke/gasp in your sleep Being treated for high blood pressure Neck size (shirt collar) over 17" (men) or 16" (women)

Y	N	SOCIAL
		Have you ever consumed alcohol or used recreational drugs?
		Do you consume alcoholic beverages? If yes...... How many times in the past year have you had 4 (women), 5 (men) or more drinks in a single day? ________________________
		Do you use recreational drugs?
		Have you ever smoked cigarettes? For how many years? ____________ How many packs per day? ____________
		Are you a former smoker? **If yes**, when did you quit? Month____________Year _________
		Have you ever used tobacco (other than cigarettes)? **If yes**, what type? _______________________________________
		Do you use electronic cigarettes?
		Do you have problems or conditions not listed above? ____
		Do you have a condition requiring accommodation?

MEDICATIONS AND ALLERGIES

List any current or recent medications you take:

Allergies or reactions to any medicines?

Medication name: ____Reaction: ____

Medication name: ____Reaction: ____

Medication name: ____Reaction: ____

Medication name: ____Reaction: ____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my treatment and my treatment results.

Your signature: ____

Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means. This would include mailing correspondence to the individual's office instead of the individual's home, emailing correspondence (via secure email server) and/or the use of text messaging systems.

I wish to be contacted in the following manner (check all that apply):

Home Phone (______)___________________________

______O.K. to leave message with detailed information

______Leave message with callback number only

Cell Phone (_____)______________________________

______O.K. to leave message with detailed information

______Leave message with callback number only

______O.K. to text appointment information

______O.K. to text account/financial information

Work Phone (______)__________________________

______O.K. to leave message with detailed information

______Leave message with callback number only

Written Communication - U.S. Mail/Fax

_______O.K. to mail to my home address

_______O.K. to mail to my work/office address

_______O.K. to fax to number indicated below

Fax # (_____)_______________________________

Written Communication - E-mail (via secure email server)

_______O.K. to email appointment information

_______O.K. to email account/financial information

Email Address:

____

I hereby grant permission for Ohio State Upper Arlington Dentistry providers and/or representatives to share clinical and financial information with or answer questions from (check all that apply and print name or names):

______ Spouse____

______ Parent____

______ Child____

______ Other (name and specify relationship):______________________________________

______ Direct patient contact only

_______________________________________ _______________________________________

Patient or Guardian Signature | Print Name of Patient or Guardian

Date Signed____________________________