THE OHIO STATE UNIVERSITY COLLEGE OF DENTISTRY
PATIENT REGISTRATION INFORMATION
PLEASE PRINT LEGIBLY

Today's Date: _____ ☐ **NEW PATIENT** ☐ **PREVIOUS PATIENT**

Patient Information

First Name: _____ Last Name: _____ Middle Name: _____

Please select one Nickname: _____

SSN: _____/_____/_____

Birth Date: _____/_____/_____ Gender: ☐ M ☐ F
Month Day Year

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

E-Mail: _____ Cell Telephone: (_____)_____

Work Telephone: (_____)_____ Extension: _____ Preferred Call Times: _____
Area code

Home Telephone: (_____)_____ Can you be Contacted at Work: ☐ Yes ☐ No
Area code

Language: ☐ English ☐ Spanish ☐ French ☐ Other _____

Race: ☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ Other

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other

School Patient Attends: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

In Case of Emergency, Please Notify

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____)_____ Work Telephone: (_____)_____
Area code Area code

Pager: (_____)_____ Cell Telephone: (_____)_____
Area code Area code

Signature _____ Date _____

(CONTINUED ON BACK)

Person responsible for payment (if different from first page)

Personal Information

First Name: _____ Last Name: _____ Middle Name: _____

Please select one Nickname: _____

SSN: _____/_____/_____

Birth Date: _____/_____/_____ Gender: ☐ M ☐ F
Month Day Year

Please Indicate below the address and phone number where you can be contacted

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

E-Mail: _____ Cell Telephone: (_____)_____

Work Telephone: (_____)_____ Extension: _____ Preferred Call Times: _____
Area code

Home Telephone: (_____)_____
Area code

Please check appropriate box

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____

Other Information

Please list other family members seen in our office: _____

Referring Doctor(s) Name: _____ Telephone: (_____)_____
Area code

Whom may we thank for referring you to our office? _____

Signature _____ Date _____

INSURANCE INFORMATION

Patient Name: _____ Today's Date: _____
(first) (last)

Primary Dental Insurance **None** ☐

Effective Date: _____

Dental Insurance Carrier: _____ Telephone Number: (___) _____
Area code

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

SUBSCRIBER INFORMATION:

Subscriber Name: _____ Birth Date: ___/___/___
Month Day Year

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____

Group or ID Number: _____ SSN: ___/___/___

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance **None** ☐

Effective Date: _____

Dental Insurance Carrier: _____ Telephone Number: (___) _____
Area code

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

SUBSCRIBER INFORMATION:

Subscriber Name: _____ Birth Date: ___/___/___
Month Day Year

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____

Group or ID Number: _____ SSN: ___/___/___

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Medicaid Number: _____

Columbus Health Plan Number: _____

Referring Doctor Name(s): _____ Telephone Number: (___) _____
Area code

Address: _____ City: _____ State: _____ Zip: _____

Continued on Back

INSURANCE INFORMATION -continued

Patient Name: _____ (first) _____ (last) Today's Date: _____

Primary Medical Insurance **None** ☐

Effective Date: _____

Medical Insurance Carrier: _____ Telephone Number: (___) _____ Area code

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

SUBSCRIBER INFORMATION:

Subscriber Name: _____ Birth Date: ___/___/___ Month Day Year

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____

Group or ID Number: _____ SSN: ___/___/___

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Medical Insurance **None** ☐

Effective Date: _____

Medical Insurance Carrier: _____ Telephone Number: (___) _____ Area code

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

SUBSCRIBER INFORMATION:

Subscriber Name: _____ Birth Date: ___/___/___ Month Day Year

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____

Group or ID Number: _____ SSN: ___/___/___

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Medicaid Number: _____

Columbus Health Plan Number: _____

Referring Doctor Name(s): _____ Telephone Number: (___) _____ Area code

Address: _____ City: _____ State: _____ Zip: _____

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

College of Dentistry
Adult Medical History

Patient Name: _____ Date of Birth _____ Today's Date _____
Last *First* *M.I.*

PLEASE SELECT THE CORRECT ANSWER

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 ANSWER "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?

MEDICINE: _____

REACTION: _____

MEDICINE: _____

REACTION: _____

MEDICINE: _____

REACTION: _____

MEDICINE: _____

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.

dentalfacultypractice
at The Ohio State University

Dental Faculty Practice
Supplemental Medical History
for Surgery and Anesthesia

Patient Name: _____ Today's Date: _____
Last *First* *Middle Initial*

Date of Birth: _____

PLEASE ANSWER THESE QUESTIONS:

LIST TREATING PHYSICIANS AND DENTISTS - PLEASE INCLUDE YOUR PRIMARY CARE PHYSICIAN, DENTIST, AND ANY SPECIALISTS CARING FOR YOU

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

NAME: _____ SPECIALTY: _____

ADDRESS: _____ PHONE: _____

ADDITIONAL QUESTIONS FOR SURGERY AND ANESTHESIA

PAST SURGERY (please list operation and year):	YES	NO	**OFFICE USE ONLY**
_____			
_____			
PAST ANESTHETICS (please describe):	YES	NO	
_____			
PROBLEMS/COMPLICATIONS OF SURGERY OR ANESTHESIA (please describe):	YES	NO	
_____			
PROBLEMS WITH ANESTHESIA FOR **FAMILY MEMBERS** (relationship, describe):	YES	NO	
_____			

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

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 OSU College of 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

CONTACT INFORMATION

The Division utilizes an automated telephone attendant to ensure quality customer service. Please be patient and follow the prompts. You will reach the correct staff member quicker by doing so.

Telephone: 614.292.2212
Facsimile: 614.292.1103
Physical Address: 2nd Floor, Postle Hall
305 West 12th Avenue
Columbus, Ohio 43210

CANCELLATION POLICY

Appointments cancelled with less than 48 business hours notice are considered *broken appointments*.
For consultations, the patient may be dismissed from the care of the Division of Oral and Maxillofacial Surgery after two (2) broken appointments. For surgery appointments, the patient may be dismissed from the care of the Division of Oral and Maxillofacial Surgery after one (1) broken appointment.

FINANCIAL POLICY – *Resident Clinic patients refer to College of Dentistry Policy. Information below pertains to patients of the Dental Faculty Practice ONLY.*

Patients are financially responsible for the entire balance of their treatments. Should there be an overpayment by the patient reflecting a credit balance, the patient will have the option of having that credit amount returned to them or utilized for future treatment. If a patient balance exceeds 30 days, it is considered delinquent and is subject to further collection action by an outside collection agent.

For patients without insurance, or for treatment by a doctor who is not a participating doctor on the patient's insurance plan, payment in full is required on the day services are rendered.

For insured patients, co-payment is required in full on the day service is rendered. Our billing staff will file claims on your behalf; in the event that the claim is returned, denied, or partially paid, the full balance becomes the patient's responsibility and is due within 30 days.

For divorced parents, the parent authorizing treatment for a child will be the parent responsible for the charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

The Division accepts the following forms of payment: cash, check, cashier's check, VISA, MasterCard, Discover, American Express, and CareCredit. CareCredit is a medical line of credit which may be available to you after a credit check and approval at an interest-free rate for a limited period of time. The Division does not make internal payment arrangements.

In cases of major surgery, patient may be required to pay a deposit to secure operating room time.

A NOTE ON CONSULTATIONS AND REFERRALS

The Division accepts new patients on a case by case basis based on the availability of our limited resources. At any given time, our resident clinic may or may not be accepting new patients from referral sources outside the College of Dentistry. The resident clinic always accepts patients for surgical services who are current patients of the College of Dentistry (have had a comprehensive or periodic examination within 24 months by a resident or dental student). The Division reserves the right to dictate resident-level or faculty-level care based on these resources and surgical complexity of the case.

As specialists, we require a written referral for all services. We also require a consultation prior to surgery. In all cases, your first appointment with the Division will not be for surgical services. This enables our practitioners to meet you, perform an examination, discuss treatment and anesthetic options with you, and present you with a comprehensive treatment plan including your financial liability.

DIRECTIONS

The following directions are general directions to the College of Dentistry. There is often construction in the University area. For patients who have access to the internet, up-to-date construction and parking information can be found at: dentistry.osu.edu/Directions_and_Map.php

From the North

Take any major highway to I-270
Take I-270 to State Route 315 South
Take State Route 315 South to the King/Kinnear Rd. Exit
Turn Left on to Kinnear Road (Kinnear Road turns into Olentangy River Road)
Take Olentangy River Road to King Avenue (third traffic light)
Turn Left onto King Avenue
Take King Avenue to Cannon Drive
Turn Left onto Cannon Drive. **Follow directions below to find parking.**

From the South

Take any major highway to I-71 North
Take I-71 North to State Route 315 North
Take State Route 315 North to the Medical Center Drive and King Avenue Exit
At the traffic light, turn Left onto Cannon Drive. **Follow directions below to find parking.**

From the East

Take any major highway to I-70 West
Take I-70 West to State Route 315 North
Take State Route 315 North to the Medical Center Drive and King Avenue Exit
At the traffic light, turn Left onto Cannon Drive. **Follow directions below to find parking.**

From the West

Take any major highway to I-70 East
Take I-70 East to State Route 315 North
Take State Route 315 North to the Medical Center Drive and King Avenue Exit
At the traffic light, turn Left onto Cannon Drive. **Follow directions below to find parking.**

ONCE YOU ARRIVE ON CAMPUS – TO FIND PARKING:

Take Cannon Drive to 12th Avenue
Turn Right onto 12th Avenue
The 12th Avenue Garage (Garage K) is located on the left (north) side of 12th Avenue
Go to the ground level and cross 12th Avenue
In the building look to the left for a glass door labeled “Dental Clinic”
Take elevator to floor 2.
Exit elevator, turn right, and walk straight down hallway towards “Oral and Maxillofacial Surgery”
Check in at Oral Surgery reception desk