OHIO COSMETIC DENTISTS, LLC

1010 BETHEL ROAD • COLUMBUS, OH 43214
614-459-7300

Patient's Name _____ M _ F_ Preferred Name _____
How did you hear about our office? _____
Your address _____
City_____ State _____ Zip _____
Home Phone _____ Business _____
Cell Phone _____ Text Y N
Date of Birth _____ Age _____
Social Security # _____
Employer_____
Physician's Name _____
Reason for dental visit_____
Email address_____

Dental Insurance Company and Phone #:
_____
Policy Holder_____
Policy Holder Date of Birth _____
Policy Holder SS#_____
Policy Holder Employer_____
Policy Holder Phone #_____
Emergency Contact_____
Relationship_____
Phone # _____

Current Medications _____

Medication Allergies ☐ Yes ☐ No If yes:_____

Taking Bisphosphonates? ☐ Yes ☐ No FOR WOMEN ONLY: Are you Pregnant? ☐ Yes ☐ No If yes, due date:_____

AIDS/HIV Positive	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No		☐ Type I or ☐ Type II	High Cholesterol	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Irregular Heart Beat	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	G.I. Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Birth Control	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No		
Congenital Heart Disorder	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No		

SURGERIES? ☐ Yes ☐ No If yes, please list procedure(s) and date(s):_____

Do you take a pre-medication? ☐ Yes or ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. The undersigned hereby authorizes this practice to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough dental diagnosis. I also authorize this practice to perform treatment and dispense medication as necessary in connection with (Name of Patient) _____. I also understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. In the event of default, I agree to pay interest on the indebtedness, together with collection costs and attorney fees as may be required for collection of this note. If I do not have dental insurance, I will pay in full at the time of service unless otherwise approved by office staff.

Patient / Responsible Party Signature _____ Date _____

Responsible Party _____ Relationship to Patient _____