Blue Ash Family Dentistry :) Dr. Bartnik

4739 Cornell Road
Blue Ash, OH 45152
513-489-6808

Patient Full Name: _____ 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? _____

Do you have a family member that sees us? _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____

Policy Holder's (PH) Full Name _____ PH Date of Birth _____

Relation to patient _____ PH SS# _ _ _-_ _-_ _ _ _

Member ID # _____

Is this dental insurance from an Employer? (circle) **Yes**. **No, individual plan.**

If yes, Employer: _____ Group Policy # _____

Secondary Dental Insurance: *(no secondary coverage? Skip this portion)*

Name of Insured/ Spouse _____ SS# _____

Relation to patient _____

DOB _____ Employer _____

Carrier _____ Group Policy # _____

RESPONSIBLE PARTY (If patient is a minor)

Name _____ Relation _____

Address _____ Phone number _____

Reason for visit today: _____

Please indicate with a circle if you are currently experiencing:

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

Please indicate with a circle any sensitivity to: Hot Cold Sweet Biting/Pressure

Physician's Name _____ Last physical examination _____

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

Dental Office Address: _____ Phone number _____

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
Multiple Sclerosis
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

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 for 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 acknowledge that I have received and read a copy of the Notice of Privacy Practices Sheet.
* 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.
(Accounts that exceed $300 can be put on a monthly payment plan for 6 months.)
* I understand that Blue Ash Family Dentistry has a 24hr cancellation policy to change or cancel an appointment or there will be a **$25 fee**.
*By providing your mobile phone number, you consent to receive text messages about appointments, updates, and billing. Message frequency varies. Reply STOP to opt-out. Standard text rates apply.
*By providing an email address, you consent to receive communications about appointments, updates, and billing. Message frequency varies. Reply STOP to opt-out.

X _____

Date:

Patient/ Legal Guardian