Blue Ash Family Dentistry :) Dr. Bartnik

4739 Cornell Road
Blue Ash, OH 45241
513-489-6808

Patient Full Name:_____ Appointment 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? _____

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 #_____

Second Carrier or Spouse Information: *(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 numbers Home_____ Work_____Cell_____

Reason for visit today: _____

Is there anything you would like to speak with the doctor about in private? No Yes

Do you have a family member that sees us?_____

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 Local Anesthetic
Barbiturates Penicillin
Codeine Sulfa
Iodine Metals
Latex 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	Shortness of Breath	Hives or Skin Rash
Heart Problems	Emphysema	Kidney Trouble
Heart Surgery	Cold Sores	Hemophilia
*Congenital Heart Problems	Oral Herpes	Angina Pectoris
Liver Disease/Jaundice	Emphysema	Glaucoma
High Blood Pressure	Fainting or Dizzy Spells	*Steroid Treatment
Eating Disorder	Arthritis	Epilepsy or Seizures
*Any type of Implant _____	Fosomax	Bruise Easily
*Any type of Transplant	Persistent Cough	Tuberculosis (TB)
*Artificial Joint	Asthma	HIV+
Sinus Trouble	Use of Tobacco Products	Bisphosphonate Treatment
Sickle Cell Disease	Hepatitis A B C Other	Dentures or Partials
Thyroid Disease	Drug Addiction	Stroke
Anemia	Alcoholism	Radiation/Chemo Therapy
Blood Transfusion	Ulcers	Diabetes
Psychiatric Treatment	Multiple Sclerosis	

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

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 to 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 over $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 I will be charged a **$25 fee**.

X _____ Date:

Patient/ Legal Guardian