MARIA VAN HUFFEL, DDS

960 N. Hamilton Road, Suite 107 | Gahanna, Ohio 43230
Phone: 614-467-8999 **Fax:** 614-478-0619
www.mvanhuffel.com

Thank you for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Today's Date

Name | Birthday | Social Security Number

Address | City | State | Zip Code

Home Phone | Business Phone | Cell Phone

Email Address - Would you like to receive appointment reminders by email? | Drivers License Number

Marital Status Single Married Divorced Widowed Other | Patient Employer | Occupation

Employer Address | City | State | Zip Code

Spouse / Partner Name | Spouse / Partner Phone | Relationship to Patient

Whom / what may we thank for referring you?

Emergency Contact (Someone who does not live with you) | Emergency Contact Phone Number | Relationship to Patient

Responsible Party

Name of Person Financially Responsible for this Account

Relationship to Patient | Is this Person a Patient in Our Office?

Address (if different from above) | City | State | Zip Code

Social Security Number | Birthday | Drivers License Number

Home Phone | Business Phone | Cell Phone

Primary Dental Insurance Information

Name of Insured | Relationship to Patient

Social Security Number | Birthday | Drivers License Number

Name of Employer | Date Employed

Employer Address | City | State | Zip Code

Insurance Company | Group Number | Employer Number

Insurance Company Address | City | State | Zip Code

Additional Dental Insurance Information

Name of Insured | Relationship to Patient

Social Security Number | Birthday | Drivers License Number

Name of Employer | Date Employed

Employer Address | City | State | Zip Code

Insurance Company | Group Number | Employer Number

Insurance Company Address | City | State | Zip Code

Over Please

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Medical History

Patient Name	Birthday

Although dental personnel primarily treat the area in and around your mouth, your mouth is party of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? ☐ Yes ☐ No
  If yes, please explain? _____
- Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
  If yes, please explain? _____
- Have you ever had a serious head or neck injury? ☐ Yes ☐ No
  If yes, please explain? _____
- Are you taking any medications, pills or drugs? ☐ Yes ☐ No
  If yes, please explain? _____
- Do you take, or have you ever taken, Phen-Fen or Redux? ☐ Yes ☐ No
  If yes, please explain? _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosponates? ☐ Yes ☐ No
  If yes, please explain? _____
- Are you on a special diet? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Do you use controlled substances? ☐ Yes ☐ No

- Are you pregnant/trying to get pregnant? ☐ Yes ☐ No • Taking oral contraceptives ☐ Yes ☐ No • Nursing ☐ Yes ☐ No
- Are you allergic to any of the following?
  ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs ☐ Other
  If yes, please explain? _____

- Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Anephyiaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Faining Spells/Dizziness	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
									Yellow Jaundice	☐ Yes	☐ No

- Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain? _____

Patient Dental History

Name of Previous Dentist	Last Exam Date

Do your gums bleed?	☐ Yes	☐ No	Do you like your smile/color of teeth?	☐ Yes	☐ No	Do you have sores/lumps in mouth?	☐ Yes	☐ No
Do you clench/grind your teeth?	☐ Yes	☐ No	Have you had orthodontic treatment?	☐ Yes	☐ No	Do you wear dentures/partials?	☐ Yes	☐ No
Do you bite your lips/cheeks?	☐ Yes	☐ No	Do you have pain or sensitive teeth?	☐ Yes	☐ No	Have you had head/neck/jaw injuries?	☐ Yes	☐ No

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. 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 during the period of such Dental care to third party payers and/or heath care practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature _____ Date _____

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Health Insurance Portability and Accountability Act

Please answer all the questions may marking the appropriate box/filling in blanks. Thank you.

Patient Name

- May we audibly say your name in our patient lobby, in order to identify you? ☐ Yes ☐ No
- May we use all of your contact numbers and addresses to stay in touch with you? ☐ Yes ☐ No
- May we leave messages in your absence? ☐ Yes ☐ No
- With whom may we discuss your dental care?

Name	Relationship to Patient

- Who can pick up your written prescriptions?

Name	Relationship to Patient

- We routinely give reminder calls prior to appointments. Where can we reach you?

Home Phone	Business Phone	Cell Phone

- May we call you at work? ☐ Yes ☐ No

Consent Related to the Privacy Notice:
I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the privacy notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but the practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Signature of Patient/guardian _____

Date of Birth _____ **Date** _____

Patient Unable To Sign Due To: _____

Patient Refused To Sign
Witness _____ **Date** _____

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Appointment Guidelines & Agreement

Since providing quality treatment for all of our patients in a timely manner is a major focus on our practice philosophy, we would like to clarify our appointment guidelines with you and ask that you assist us in this endeavor.

There will be absolutely no charge for your need to reschedule an appointment provided you give us 48 hours notice and that you contact us during business hours, this would allow us the opportunity to give this time to another patient who is in need and waiting.

Last minute cancellations can cause hardships for many individuals. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice.

Thank you.

_____ _____

Signature of Patient/guardian **Date**

Maria Van Huffel, D.D.S. _____ **(Initial)**