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)**

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Thank you for choosing our office for your dental needs. We do our absolute best to help you estimate your insurance benefits. As a courtesy, our office will verify your insurance with your insurance carrier as long as you provide us with your correct insurance information no less than 2 business days before your appointment. We will file your dental claim with your insurance carrier. Keep in mind all insurance companies include a disclaimer stating verification does not guarantee payment.

Due to the thousands of insurance plans, it would be impossible for us to know all benefits, allowances and limitations on all plans. You must be familiar with your own benefits. Your dental insurance plan is a contract between you, your employer, and the insurance company. *It is your responsibility to know the benefits, limitations and exclusions of your dental* plan. If you are unhappy with your coverage, please contact your Human Resources Department. Only your employer can change the policy. *We are not responsible, nor can we guarantee, how your insurance carrier will pay on a claim.*

When Dr Van Huffel recommends treatment, you will always be presented with a treatment plan for the services. Treatment plans sometimes change during the course of treatment because conditions worsen and therefore your financial responsibility would also change. This would always be discussed with you before service is rendered. The entire fee for services is your responsibility regardless of insurance involvement. Because your insurance company makes no guarantee of payment, we cannot guarantee your exact insurance coverage. Your deductible and estimated portion are due at the time services are rendered; this includes any children coming to appointments without parents. You may receive a statement with an additional balance after your insurance has paid the portion they decide to pay. Once the insurance carrier has paid, the remaining balance is still your responsibility.

We are always available to answer your questions and assist you in any way we can.

Thank you,

Dr. Van Huffel

I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for treatment performed on me and my dependents. It is my responsibility to notify the office of any changes in my insurance. I understand that *payment will be due on the day service is rendered, even if my child comes to the office without a parent.*

_____

Sign Name Print Name Date

COVID-19 Patient Waiver

Dr. Van Huffel has the utmost concern for my health and safety. The guidelines from governing bodies are sometimes vague and conflicting and Dr. Van Huffel is working diligently to determine how to continue to care for patients while keeping the team and public as safe as possible. I understand that there is a real risk of being exposed to the COVID-19 when coming in contact with the general public. This can happen at the grocery store, gas station or other public place.

The Governor of Ohio, Ohio Dental Board, ADA, CDC and other agencies have issued guidelines to decrease risk. It is my personal responsibility to be aware of and follow these guidelines to protect myself and my family. I also understand that these guidelines are changing daily, and it is my personal responsibility to keep up on all of the changes and make my own decisions for my health and that of my family.

In the process of being treated in a dental office I am coming in contact with the general public. I am in close proximity or direct contact with a number of people throughout the visit that may have been exposed to the COVID-19 virus and may not be symptomatic. Dr. Van Huffel is taking every possible precaution, but there is no guarantee that I will not come in contact with someone who has the virus in this office. Dr. Van Huffel is implementing current guidelines to keep me safe. I understand that I am allowed to go home at any point if I do not feel safe. I will bring to Dr. Van Huffel's attention any procedure or situation that I feel increases the risk of transmission to others.

I have been given the option by Dr. Van Huffel to cancel or reschedule my appointment. There will be no negative consequences to my future relationship here if I choose to go home. By signing this form, I am stating that I have not had any flu symptom and I do not have a fever. I have not traveled to a high-risk area in the last 14 days or been in close contact with someone who has been diagnosed with or is under investigation for COVID-19 and/or if they have a cough, fever or shortness of breath.

By signing this form, I am choosing to be treated today and I accept the risks of being here.

_____ Printed Name

_____ Signature

_____ Date